DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

COLOMBIA

HEALTH CARE AND SOCIAL SECURITY REFORM PROGRAM

(CO-0265)

LOAN PROPOSAL

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CONTENTS

ANNEXES

BASIC SOCIOECONOMIC DATA

For basic socioeconomic data, including public debt information, please refer to the following address:

http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata

INFORMATION AVAILABLE IN THE RE3/SO3 TECHNICAL FILES

Preparation:

Draft plan for the structural reorganization of public hospitals

Technical paper on the net fiscal impact of public hospital reform

Technical paper on the net fiscal impact of the ISS-ESE reform

Paper on the impact in terms of pension liabilities of conversion from the civil-service to the public-sector employment regime

Report on implementation of the economic program

ABBREVIATIONS

AP	Administradora de Pensiones [Pension Administration Board]
ARP	Administradora de Riesgos Profesionales [Occupational Risk Administrative Board]
ARSs	Administradoras del Régimen Subsidiado [Subsidized System Administrators]
BSC	Bank's strategy with the country
CCFs	Cajas de Compensación Familiar [Family Allowance Funds]
CNSSS	Consejo Nacional de Seguridad Social en Salud [National Council on Social Security in Health Care]
CONFIS	Consejo Superior de Política Fiscal [Supreme Council on Fiscal Policy]
DIAN	Dirección de Impuestos de Aduanas Nacionales [National Customs Bureau]
DNP	Departamento Nacional de Planeación [National Planning Department]
EPS	Empresa Promotora de Salud [Health Promotion Enterprise]
ESEs	Empresas Sociales del Estado [State Social Enterprises]
GDP	Gross domestic product
IDB	Inter-American Development Bank
IMF	International Monetary Fund
IPS	Institución Prestadora de Salud [Health Care Provider]
ISS	Instituto de Seguros Sociales [Social Security Institute]
MPS	Ministerio de Protección Social [Ministry for Social Welfare]
OC	Ordinary Capital
PBL	Policy-based loan
POS	Plan Obligatorio de Salud [Mandatory Health Plan]
PTI	Poverty-targeted investment
SBA	Stand-by arrangement
SGP	Sistema General de Participaciones [General Revenue Sharing System]
SGSSS	Sistema General de Seguridad Social en Salud [General Social Security Health Care System]
SISBEN	Sistema de Clasificación de Beneficiarios de Programas Sociales [Social Program Beneficiary Classification System]
UPC	Unidad de Pago por Capitación [Capitation Payment Unit]

INTERAMERICAN DEVELOPMENT BANK
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COLOMBIA

IDB LOANS

APPROVED AS OF AUGUST 31, 2003

	US$Thousand	Percent
TOTAL APPROVED	**10,113,041**	
DISBURSED	9,190,295	90.87 %
UNDISBURSED BALANCE	922,746	9.12 %
CANCELATIONS	978,993	9.68 %
PRINCIPAL COLLECTED	4,714,784	46.62 %
APPROVED BY FUND		
ORDINARY CAPITAL	9,296,527	91.92 %
FUND FOR SPECIAL OPERATIONS	754,656	7.46 %
OTHER FUNDS	61,858	0.61 %
OUSTANDING DEBT BALANCE	**4,475,511**	
ORDINARY CAPITAL	4,287,868	95.80 %
FUND FOR SPECIAL OPERATIONS	187,358	4.18 %
OTHER FUNDS	285	0.00 %
APPROVED BY SECTOR		
AGRICULTURE AND FISHERY	549,942	5.43 %
INDUSTRY, TOURISM, SCIENCE AND TECHNOLOGY	512,425	5.06 %
ENERGY	2,728,166	26.97 %
TRANSPORTATION AND COMMUNICATIONS	715,347	7.07 %
EDUCATION	86,121	0.85 %
HEALTH AND SANITATION	735,864	7.27 %
ENVIRONMENT	131,047	1.29 %
URBAN DEVELOPMENT	405,575	4.01 %
SOCIAL INVESTMENT AND MICROENTERPRISE	2,338,222	23.12 %
REFORM AND PUBLIC SECTOR MODERNIZATION	1,875,866	18.54 %
EXPORT FINANCING	0	0.00 %
PREINVESTMENT AND OTHER	34,466	0.34 %

* Net of cancellations with monetary adjustments and export financing loan collections.

Inter-American Development Bank
Regional Operations Support Office
Operational Information Unit

Colombia

Tentative Lending Program

2003

Project Number	Project Name	IDB US$ Millions	Status
CO0268	Social Emergency Program	1,250.0	APPROVED
CO0258	Attorney General's Office Support & Strengthening	14.0	APPROVED
CO0265	Health and Social Security Reform Program	400.0	
CO0241	Social Housing Program	150.0	
CO0139	Health Services Networks Modern. Prog.	70.0	
CO0266	National Public Service Modernization Program	16.0	
	Total - A : 6 Projects	**1,900.0**	
	TOTAL 2003 : 6 Projects	**1,900.0**	

2004

Project Number	Project Name	IDB US$ Millions	Status
CO0262	National Environmental System Support Program	35.0	
CO0270	Public Regulation Services Program	N/A	
CO0263	Infrastructure Privatization and Concessions II	20.0	
CO0267	Environmental Sanitation of Bogota - Phase I	50.0	
CO1001	Transport Sector Support Program	200.0	
	Total - A : 5 Projects	**305.0**	
	TOTAL - 2004 : 5 Projects	**305.0**	
	Total Private Sector 2003 - 2004	**0.0**	
	Total Regular Program 2003 - 2004	**2,205.0**	

*** Private Sector Project**

COLOMBIA

STATUS OF LOANS IN EXECUTION

AS OF AUGUST 31, 2003

(Amount in US$ thousands)

APPROVAL PERIOD	NUMBER OF PROYECTS	AMOUNT APPROVED*	AMOUNT DISBURSED	% DISBURSED
REGULAR PROGRAM				
Before 1997	**8**	**240,083**	**185,506**	**77.27 %**
1997 - 1998	**8**	**208,627**	**163,017**	**78.14 %**
1999 - 2000	**4**	**344,100**	**138,445**	**40.23 %**
2001 - 2002	**5**	**500,700**	**400,325**	**79.95 %**
2003	**2**	**1,264,000**	**750,000**	**59.34 %**
TOTAL	**27**	**$2,557,510**	**$1,637,293**	**64.02 %**

* Net of cancellations. Excludes export financing loans.

HEALTH CARE AND SOCIAL SECURITY REFORM PROGRAM

(CO-0265)

EXECUTIVE SUMMARY

Borrower:	Republic of Colombia	
Executing agency:	Ministry of Finance and Public Credit, through its Office of the Deputy Minister for Operations and in coordination with the Departamento Nacional de Planeación [National Planning Department] (DNP)	
Amount and source:	IDB (OC):	US$400 million
	Total:	US$400 million
Financial terms and conditions:	Amortization period:	20 years
	Grace period:	5 years
	Disbursement period:	18-36 months
	Interest rate:	adjustable
	Inspection and supervision:	1%
	Credit fee:	0.75%
	Currency:	US dollars under the Single Currency Facility
Objectives:	The program's objective is to backstop the government's efforts to improve the coverage, quality, equity, and financial sustainability of the health care component of the social security system over the medium term.	
Description:	The loan will be disbursed in two tranches (US$250 million in the first and US$150 million in the second) in accordance with the policy matrix shown in Annex I and the means of verification set forth in Annex II. Actions in the following four areas will be conditions precedent to the release of the disbursements: (i) macroeconomic stability; (ii) financial sustainability and efficiency of the subsidized regime administered by the Sistema General de Seguridad Social en Salud [General Social Security Health Care System] (SGSSS); (iii) financial sustainability and efficiency of the Instituto de Seguros Sociales [Social Security Institute] (ISS); and (iv) efficiency, transparency, and equity in the Cajas de Compensación Familiar [Family Allowance Funds] (CCFs).	

The objective of the first component is to ensure that the macroeconomic environment is conducive to the achievement of the program's objectives. The second is aimed at increasing the number of people covered by the system, the quality of service, and the equity of resource allocation in order to provide greater benefit to the poorest sectors of the population and build a sustainable financial foundation for the health care system. The third component's objective is to place the ISS on a sustainable financial footing in the medium and long terms and to improve the quality of its services. The fourth and final component is designed to create institutional mechanisms for ensuring transparency and accountability and to introduce policies and regulations that will make the family allowance system more equitable.

The Bank's country and sector strategy:

The Bank's strategy with the country (BSC) establishes three main lines of action for 2003-2006: (i) laying the foundations for reactivating and galvanizing the economy; (ii) promoting social development and providing protection for the most vulnerable sectors of the population, and (iii) enhancing governance and supporting State reforms. The BSC also identifies two major constraints: the fiscal deficit, and the escalation of the conflict in the country. The gradual resolution of these two constraints is an underlying assumption upon which the strategy's success is based.

In terms of the main BSC lines of action, this operation will primarily contribute to the second objective. By supporting efforts to reform the health care system and restructure the ISS, it will contribute to the provision of financially sustainable social services that will cover the population's needs more effectively and make more efficient use of available resources. At the same time, by helping to strengthen the ISS and enhance the transparency of the CCFs, it will be contributing to the achievement of the third objective. In addition, the steps to be taken to place the ISS and public hospitals in a stronger financial position, which will in turn contribute to an improvement in national finances and financial accounts at subnational levels, will help to mitigate the constraints associated with the fiscal deficit. Within the framework of the stand-by arrangement (SBA) reached with the International Monetary Fund (IMF), this loan operation will also help to cover Colombia's financing requirements for 2003-2005.

Environmental and social review:

The program does not entail any physical or other investment projects and will therefore have no direct environmental impact. In order to serve indigenous and Afro-Colombian minorities, the program will include this ethnic variable in the ongoing adjustment and monitoring system of the Plan Obligatorio de Salud [Mandatory Health Plan] (POS) and will give priority to indigenous groups in allocating health care subsidies.

Coordination with other multilateral agencies:

The health care reforms launched in Colombia in 1993 are one of the most ambitious social initiatives to be undertaken in Latin America. Through five different operations designed and executed over the past 10 years, the Bank has been the multilateral agency most closely involved in this process. Its support has been focused on the most important areas of this reform effort: (i) modification of formulas and guidelines for transfers to subnational units; (ii) pilot projects on the structural reorganization of public hospitals; (iii) coverage for vaccination costs; (iv) regulations aimed at improving SGSSS management; and (v) initial ISS reforms. Work in this last area has also been supported by the World Bank. The current operation provides continued support for government reform initiatives within the framework of the structural reforms and goals included in the SBA.

Multilateral agencies and the government are also coordinating the financial aspects of the initiative. The SBA provides a frame of reference for the US$7.349 billion in financial commitments by multilateral agencies that have been approved for 2003-2006. Of that amount, approximately US$4.7 billion will be in the form of fast-disbursing funds (53% to be approved in 2003).

Benefits:

In the medium term, the proposed reforms for enhancing the efficiency and financial sustainability of the subsidized SGSSS regime will be reflected in a substantial reduction in public hospitals' operating and cumulative deficits. At the same time, within the limits imposed by the country's serious fiscal constraints, significant progress is expected toward the attainment of universal coverage. Within the framework of the component focusing on the efficiency and financial sustainability of the ISS, by the end of this three-year period the Empresas Promotoras de Salud [Health Promotion Enterprises] (EPSs) will have brought their expenditures into line with the revenues generated by their registered beneficiaries and will thus be able to balance their financial accounts. In addition, the conversion of the Instituciones Prestadoras de Salud [Health Care Providers] (IPSs) into various Empresas Sociales del Estado [State Social Enterprises] (ESEs) will do a great deal to curb the growth of pension liabilities and will permit the ESEs to align the size of their operations and their payrolls with the actual demand for their services. The component dealing with the efficiency, transparency, and equity of the CCFs will help these organizations to increase their accountability and thus to generate savings. In addition, the regulation of CCF monetary subsidies will make it possible to even out the benefits received by CCF members across different regions of the country.

The net fiscal impact of the reforms in terms of the health care system's rationalization will be reflected in increasing savings as the

hospitals are organized more efficiently. Net savings are expected to rise from 0.05% of GDP in 2004 to 0.12% of GDP from 2007 on. The restructuring of the ISS is expected to generate immediate annual savings for the national government equivalent to 0.07% of GDP in 2004, after which the level of savings will gradually decline.

Risks:

Specific risks include the following: (i) There is a political risk entailed in any slowing of the pace of the reforms, their deferment, or reversal. *Mitigation*: The most important decisions regarding how to split up the ISS and restructure the hospitals were made during the program's preparatory phase. Semiannual monitoring of the program will permit any sign of diversions or deviations in the process to be identified in time. (ii) The legal vulnerability of the Unidad de Pago por Capitación [Capitation Payment Unit] (UPC) for the POS is an ongoing challenge in terms of the financial equilibrium of the SGSSS. *Mitigation:* Better health care service delivery as a result of structural reorganization will lead to a sharp decrease in complaints and petitions for injunctions filed by the public; (iii) The availability of the fiscal capacity required for the structural reorganization of public hospitals is a concern. *Mitigation*: The preliminary draft of the 2004 budget that has been sent to Congress includes the allocation needed to begin the hospitals' restructuring. (iv) Conditions conducive to a financially viable restructuring of the EPS-ISS and the ESEs are required. *Mitigation*: The proposed restructuring will allow the EPS-ISS to concentrate on the processes within its purview and to establish a contractual relationship with the ESEs. Meanwhile, the ESEs will have time to make adjustments during the transition period, when their services will be contracted by the ISS, and will receive operational support so that they can compete with other providers. (v) Incentives are needed for participating agencies (the ISS and the Ministry for Social Welfare) to fulfill the conditions set forth in the matrix. *Mitigation*: An incentive for the Ministry's fulfillment of the conditions is provided by the link between the conditionality of the process and the budgetary allocation assigned to the Ministry for Social Welfare to fund its implementation of this reform process.

Special contractual clauses:

Completion of the agreed policy actions for each tranche, as specified in Chapter II and Annex I of this document, will be conditions precedent to the release of the disbursement for the corresponding tranche.

Poverty-targeting and social sector classification:

This operation qualifies as a social equity enhancing project as described in the indicative targets mandated by the Bank's Eighth General Increase in Resources (document AB-1704) for the following reasons: (i) the rationalization of the public hospitals will permit them to expand their service coverage, with emphasis on the lowest-income groups; and (ii) the restructuring of the ISS and the CCFs is expected to lead to greater equity in the distribution of benefits, to raise the

quality of service, and to shorten the timeframes service delivery. As a policy-based loan, this operation does not qualify as a poverty-targeted investment (PTI).

Exceptions to Bank policy: None.

Procurement: Not applicable.

I. FRAME OF REFERENCE

A. Socioeconomic framework

1.1 Since the mid-1990s, the Colombian economy has slowed its pace of growth considerably. Following a short-lived growth bubble in 1998, the most severe economic crisis of the last 70 years broke out in the first quarter of 1999. In 1999 and 2000, the country had to deal with a drop in GDP, crises in the financial system and for mortgage-holders, a fiscal crisis at the subnational level, together with the materialization of contingent liabilities (pensions and concessional infrastructure guarantees), and a growing imbalance in the central government's finances. What is more, all these situations arose within a context of limited access to external financing and an escalation of activity on the part of violent groups.

1.2 These events obliged households and businesses to make economic adjustments in order to cope with the change in their liability/asset positions. By 2001 the private-sector imbalance had all but disappeared, the financial sector had emerged from the crisis, and a fiscal consolidation program was being implemented at the subnational level. When the current Administration took office in August 2002, it was confronted with the economic and social effects of a protracted bout of stagnation and a sizeable fiscal deficit at a time when the armed conflict was escalating. In response to these challenges, the new Administration worked out a structural reform plan designed to control the deficit and galvanize the economy, together with an alternative strategy for dealing with the conflict in the country. These policies have begun to have a positive impact on the Colombian economy, whose production sectors are showing signs of reactivation.

1.3 The increase in social expenditure observed during the 1990s bore witness to the country's efforts to ensure a stable supply of financing for social sectors, especially health and education.[1] However, even though more funds were allocated, no significant gains were made in terms of the efficiency of social spending. In addition, as a result of the crisis and the cuts in social expenditure that it prompted, between 1997 and 2001 the size of the population living below the poverty line and below the extreme poverty line increased, especially in urban areas. In response to this state of affairs, the current Administration has redoubled its efforts to make the delivery of social services more efficient and has committed itself to protect social welfare spending levels.

1.4 To ensure the continuation of the fiscal adjustment in coming years and the long-term sustainability of the public debt, the economic program is underpinned by a structural reform package. Reform initiatives that have won approval and are now being instituted include a tax reform, pension-system reform, the restructuring of the Instituto de Seguros Sociales [Social Security Institute] (ISS), State reform,

[1] Between 1991 and 1999, public-sector social expenditure rose from 8% to 13% of GDP.

rationalization of the health care system, and passage of the Fiscal Responsibility Act. Measures to reinforce the economic program that are currently awaiting approval include the reforms needed in order to adjust government and pension-system expenditure that are contained in the referendum, and amendments to the Budget Organization Statute and to Act No. 80 on public contracting.

1.5 Health conditions for the Colombian population have improved substantially. The infant mortality rate has declined in all but the eastern region of the country, as is indicated by the fact that for 1995-2000 the national rate was 21 deaths per 1,000 births, which is far below the average for middle-income countries. Medical care delivery figures are also high in comparison to other Andean countries, with 88% of all births occurring in a health care facility and most of these births being attended by a doctor. The health care system is faced with a number of challenges, however, including a decline in vaccination rates during the economic crisis and rising violence-inflicted injury and chronic disease rates.

B. The International Monetary Fund (IMF) program

1.6 The US$2.2 billion IMF stand-by arrangement (SBA) that was approved in January 2003 will serve as a framework for macroeconomic policy over the next two years. The program is based on assumed growth rates of 2% for 2003 and 3.3% for 2004. The initial results of the economic program are summarized in the first SBA review, which was undertaken in May 2003. This report sets forth four main conclusions: (i) the economy appears to have embarked upon a recovery fueled by domestic demand; (ii) the risks associated with the program, although significant, have diminished;[2] (iii) the government has complied with the SBA and has pledged to carry the reform process forward;[3] and (iv) the findings regarding the sustainability of the debt that were presented in the original SBA report remain valid. It should be noted that these positive results have been achieved without sacrificing basic social welfare expenditure levels, which have remained constant thanks to the support provided by the Social Emergency Program (1455/OC-CO).

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[2] Positive factors in this connection include Congressional support for the reforms and external market confidence. Factors that heighten the level of risk include: (i) the conflict within the country; (ii) the difficulties existing in Venezuela, which is Colombia's second largest trading partner; and (iii) uncertainty regarding the approval of the economic and political reforms included in the referendum.

[3] The results of the fiscal adjustment and the reforms could be seen at the close of the fiscal accounts for 2002 and during the first quarter of 2003. The consolidated public-sector deficit was 3.6% of GDP at the end of 2002, which was well below the 4.1% target figure negotiated with the IMF. The target for the first quarter of 2003 was also met, since the level agreed upon with the IMF was 0.7% of GDP, while the actual deficit amounted to 0.5% of GDP. The new inflation target for 2003 has been set at 5.9% (originally it was 5.5%) in order to account for the direct effect of the VAT rate hike (0.4 percentage points). The largest modification to result from the IMF review is in the target figure for the current account deficit, which was raised from 0.8% of GDP to 2.3% of GDP for 2003. This change reflects the downturn in exports to Venezuela and the unforeseen increase in capital goods imports.

C. Health care under the social security system

1.7 Colombia's health care reform has been described as one of the most ambitious social restructuring efforts to be undertaken in Latin America. This reform initiative was launched in Colombia in 1993 in an effort to address problems of low coverage and quality, inefficiency, and inequity in a sector that was segmented into three different levels: (i) an entirely private system offering services of a higher quality to the small, highest-income segment of the population with the ability to pay for such services; (ii) the social security system, which provided coverage to employees in the formal sector of the economy (about 20% of the total population) through the services of the ISS and other agencies; and (iii) the public, government-financed system, which served the low-income population and/or groups lacking social security coverage at the hospitals and clinics run by the Ministry of Health.

1.8 In view of these circumstances, the reform program set out three main objectives: (i) basic health care coverage for the entire population; (ii) more effective use of available resources; and (iii) higher-quality health care. These objectives are to be reached with the help of a strategy for providing benefits under a mandatory, pay-as-you-go social security system that is integrated with a decentralized health services delivery system. Colombia's health care insurance system thus had its inception in the creation of the Sistema General de Seguridad Social en Salud [General Social Security Health Care System] (SGSSS) under Act No. 100 of 1993, which serves as the principal legal framework for health care reforms.

1.9 The idea behind the creation of the SGSSS was to achieve universal health care coverage through two types of systems: a contributory plan serving approximately 70% of the population (formal- or informal-sector employees able to contribute to a pension plan), and a subsidized system for the remaining 30%, who are unable to pay contributions (the poorest workers). The insurance scheme's primary aim is to provide effective access to health care services under a differentiated Plan Obligatorio de Salud [Mandatory Health Plan] (POS) system that places emphasis on basic services for prevention, promotion, and health care services based on the delivery of cost-effective responses for low-, mid- and high-cost health problems. This scheme is designed to provide a more equitable distribution of subsidies and to furnish access to basic health care regardless of an individual's ability to pay. This reform effort is also part of the sector's subnational and institutional decentralization process, which was given concrete form in Act No. 60 of 1993 concerning revenue sharing.

1.10 Since 1993, the SGSSS has made a great deal of progress in terms of coverage, instruments, and management, particularly for the poorest sectors of the population. In 1993, nearly 24% of the Colombian population was covered by one of the country's social security or family allowance systems. In 2000, according to the results of the National Population and Health Survey taken in that year, 60% of the

total population was covered. This consolidation has also provided greater access to primary and hospital health care services for persons having SGSSS coverage.

1.11 The original projections regarding the attainment of universal health insurance and the convergence of benefit plans have not been fulfilled, however. Sharp disparities exist across regions, as is indicated by the fact that 72% of the population is covered in Bogota, whereas only 45% is in the Atlantic Region. Coverage is also greater in urban areas than in rural zones, is lower among minors and tends to increase with age, and is higher among women than men. There are many external factors that influence how much funding is available to expand the system's coverage, including the political, economic, and fiscal situation; high unemployment; and rising levels of informal employment. In addition, other factors within the SGSSS have raised expenditure levels without producing any changes in quality or coverage. This has also had a major fiscal impact on the State. These factors include the situation in the country's public hospitals, levels of evasion and avoidance, the determination and cost of POS benefits, and the situation of the ISS and the Cajas de Compensación Familiar [Family Allowance Funds] (CCFs).

1. The subsidized health care system

1.12 The process of expanding coverage to include the whole of the poor population calls for the gradual replacement of supply-side funding—the bulk of which is currently channeled to the country's public hospitals via budgets based on historical costs— with demand-side subsidies.[4] Colombia is still a long way from being able to provide universal coverage for its poor population or equity between the benefits provided in the health plans of each system. At present, 58% (9.3 million) of the country's poor population is signed up with the subsidized system, and the plan that these people have provides 54% of the benefits furnished under the contributory system. As of 1999, 25% of own resources and 35% of the funds of the Sistema General de Participaciones [General Revenue Sharing System] (SGP) had been shifted from supply-side funding to demand-side subsidies. Act No. 344 of 1996 called for 60% of the funds from both sources to have been converted to demand subsidies by the year 2000. In that same year, however, the government decided to freeze this conversion process due to the straitened financial situation of the public hospitals. Under Act No. 715 of 2001, the conversion process is to recommence in 2002.

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[4] The subsidized system receives funding from a variety of sources, including the transfer of one percentage point of the payments made by workers into the contributory system to the Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund] (FOSyGA), transfers from the national government to subnational units through the Sistema General de Participaciones [General Revenue Sharing System] (SGP), and contributions paid out of the departmental or municipal governments' own resources.

2. Public hospitals

1.13 As part of the decentralization process, the country's public hospitals have been converted into Empresas Sociales del Estado [State Social Enterprises] (ESEs). These are decentralized public agencies are legal entities in their own right, have their own assets, and enjoy administrative autonomy. Mechanisms were introduced for overhauling the public hospitals' financial and management structures and for ensuring the continued operation of those that could provide quality services efficiently. The organizational scheme instituted under the provisions of Act No. 60 of 1993 granted autonomy to subnational entities in the administration of financial resources and decision-making with regard to the supervision, administration, and provision of health care services. In many cases, however, this did not work out as expected, and many of these enterprises did not take over the responsibilities transferred to them in an effective manner. This led to a great deal of disorganization in the provision of public health care services in many parts of the country.[5]

1.14 The public hospitals are running deficits, largely because of problems in the way these institutions have handled the autonomy they have been given.[6] In 1997, the public hospitals' deficits began to widen significantly, since their revenues were increasing at less than 5% per year while their expenses were rising by over 10%. Most of the growth in expenditure was due to staff increases. This raised the level of fixed costs owing to the rigidities that exist with respect to worker entitlements and benefits.

1.15 The crisis in hospital finances is especially serious because the sector currently allocates more resources for public hospitals than it did before the reform, despite the fact that more than half of the poor population is registered with the subsidized system. This situation leads to an evident deterioration in the overall efficiency of the public hospital system, which is reflected in the fact that per capita supply-side subsidies has been increasing at the same time as the number of persons being served by those resources has been declining. The hospitals' deficits also represent an unsustainable fiscal burden for subnational governments; in fact, in 2001 they became the largest single component of the nonfinancial public sector's deficit at the subnational level. Unless reforms are instituted, the public hospitals' deficits will grow larger in the future. In fact, if current operating conditions remain unaltered, it is estimated that, by the end of 2006, the cumulative deficit for that

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5 Excessive payrolls and imbalances between professional and non-medical staffing were particular problems.

6 On the other hand, the incentives provided by the central government for overhauling the public hospitals' funding structure have not been consistent either. In addition to influencing the increase in spending levels, since the employer contributions are an assured source of funding, the direct transfers which the central government has continued to make to public hospitals has been used to cover the gap between the hospitals' expenses and their revenues.

four-year period will amount to US$750 million, or the equivalent of 0.62% of that year's GDP.

3. SGSSS evasion and avoidance

1.16 Evasion and avoidance of SGSSS contributions are significant and have an impact on the system's financial equilibrium. It is estimated that evasion and avoidance result in nearly US$710 million in lost revenues each year. These practices take the form of under-reporting of income, non-payment by active members and pensioners, and the failure of some individuals to sign up with the SGSSS, as well as arrears on the part of inactive plan members. Efforts must therefore be concentrated on rectifying this situation by improving verification and control systems, interconnecting the collection systems of the SGSSS, the Dirección de Impuestos y Aduanas Nacionales [National Customs Bureau] (DIAN), the Superintendencies, and other agencies, and establishing standards to ensure timely, accurate reporting.[7]

1.17 A study financed by the Health Services Improvement Program (716/OC-CO) in 1996 recommended that the existing system should be re-engineered to function as a comprehensive health information system based on coordinated user-oriented, user-designed, and user-enhanced data collection mechanisms capable of transferring information from one system to another in order to meet the needs of all the parties concerned. That same year, as a first step, a series of regulations were issued with a view to standardizing data, information flows, and the systems for forwarding information from one party to another.

1.18 The current status of the work on this comprehensive health information system is as follows: (i) an accurate appraisal of the Ministry for Social Welfare's information needs has been prepared; (ii) the technological infrastructure required for the consolidation of all the relevant data is not in place; (iii) development of the plans for the corresponding information systems in the Ministry for Social Welfare has lacked continuity and management support; and (iv) uniform information is not generated within the Ministry for Social Welfare itself. A need therefore continues to exist for comprehensive information that can be used to reduce evasion and corruption and to serve as a basis for decision-making, policy-making, and coordinating the actions of the various agencies.

4. Mandatory health plan

1.19 The Plan Obligatorio de Salud [Mandatory Health Plan] (POS) created by Act No. 100 of 1993 is designed to provide all Colombian residents with

[7] For example, nearly 384,00 cases have been detected in which members of supplementary pre-paid prescription plans are not paying into the contributory system, and those who are doing so are paying much less than they should be based on their real incomes as reported to the DIAN.

comprehensive protection for maternity and illness. Coverage is to be provided for wellness care, preventive medicine, diagnosis, treatment, and rehabilitation for all pathologies, with the intensiveness and the level and complexity of care being defined for each case by the Consejo Nacional de Seguridad Social en Salud [National Council on Social Security in Health Care] (CNSSS). The health care services included in the POS are updated by the CNSSS in accordance with existing needs and changes as they arise, including the financial situation of the SGSSS. Agreement No. 72 of 1997, which was signed by the Ministry of Health and the CNSSS, establishes which health care services are to be included in the subsidized POS.

1.20 The POS uses an Unidad de Pago por Capitación [Capitation Payment Unit] (UPC). This is an annual sum that permits the SGSSS contributions to be distributed equitably to cover the health insurance costs of all plan members. It is the CNSSS's job to set the value of the UPC, which is adjusted annually based on the frequency of use and unit costs, disaggregated by the members' gender, age, and region. Per capita payments of the UPC are intended to encourage the Empresas Promotoras de Salud [Health Promotion Enterprises] (EPSs) to employ cost-saving measures in administering the POS.

1.21 Since 1993, however, the methodological instruments needed in order to carry out well informed yearly adjustments of the benefits included in the plans and the UPC have not been made available. Under the Health Reform Support Program (910/OC-CO), some aspects of the SGSSS' financial balance relating to the POS and the UPC have been evaluated, but no progress has been made in assessing the relevance or cost effectiveness of the benefits included in the POS. The lack of the detailed information on POS service use levels called for by the approved adjustment methodology has blocked progress in the adjustment and prioritization of the POS benefits and their costing as a basis for setting the UPC. This may have had an impact on EPS profits and the operations and financial accounts of the SGSSS as a whole.

1.22 Although the health care services included in the subsidized and contributory POS schemes are clearly specified in the corresponding legal provisions, differing interpretations of the health care services covered in the POS have prompted beneficiaries of the system to bring claims against the State in an effort to obtain services which are not covered on a uniform basis. As a result of this situation, the Constitutional Court has ruled in favor of suits brought by plan members seeking coverage for certain types of health care services. This has given rise to uncertainty as to the law within the system, elevated financial costs, led to ineffective and experimental services being funded in some instances, and deprived other current and potential SGSSS beneficiaries of services.

5. Social Security Institute

1.23 *The ISS prior to Act No. 100.* Until 1993, the Instituto de Seguros Sociales [Social Security Institute] (ISS) was a State monopoly responsible for managing social security health coverage, occupational risk, and pensions. In all of these areas, the ISS routinely managed services for over 90% of the population having coverage. It functioned primarily as a service provider, making use of the extensive network of clinics in the country. Although passage of Act No. 100 of 1993 brought about radical changes in the regulatory environment, revenues, and monopoly status of the ISS, the Institute had anticipated these changes by authorizing prior modifications in its legal status to allow its conversion into an industrial and commercial State enterprise whose operations could then be organized into various business units.

1.24 When Act No. 100 of 1993 entered into force, the ISS had 24,000 permanent employees and 12,000 temporary contractors. Its personnel were organized into four business areas at its central and sectional levels: Empresa Promotora de Salud [Health Promotion Enterprise] (EPS), Institución Prestadora de Salud [Health Care Provider] (IPS), Administradora de Pensiones [Pension Administration Board] (AP), and the Administradora de Riesgos Profesionales [Occupational Risk Administrative Board] (ARP). Two financial and administrative support units were also created. This organizational configuration was devised in an effort to provide a flexible, effective response to the private-sector competition that would arise in the business sectors served by the ISS as a result of the 1993 reform.

1.25 *The impact of Act No. 100 and the EPS-IPS dichotomy.* The organizational separation of the EPSs and the IPSs provided for in the provisions regarding their restructuring was designed to deal with the challenges posed by the new legislation. However, the practical measures required to make the functional and financial separation of these two operations a reality have not been implemented. The effective separation of the two organizations was intended to facilitate the monitoring of revenues and expenditures and individual performance evaluations. Although the new legal framework assigned responsibility for financial oversight and risk management to the EPSs, the ISS' corporate strategy focused on boosting investment in order to expand the IPS infrastructure and devoted little effort or resources to building the administrative grid needed to give the EPSs the necessary tools for effective financial oversight and risk management. In addition, as part of its growth strategy, the ISS decided to focus the EPSs' commercial expansion drive on promoting the "strengths" which gave them a unique market position but which also increased their operating costs: (i) a benefits plan that was 35% larger and more costly than the plan approved under Act No. 100; (ii) nationwide coverage and, consequently, the maintenance of costly infrastructure in remote areas; (iii) transportation of high-cost patients to other countries; and (iv) active outreach to high-risk patients (kidney and cardiovascular conditions).

1.26 During the first years following the passage of Act No. 100, the ISS did not fulfill its mandate for generating EPS revenues by cross-referencing system accounts in order to secure the corresponding UPCs. In addition, the failure to develop adequate internal information systems meant that accurate data on the number and characteristics of plan members were not available, and the EPSs therefore had to calculate their revenues on the basis of contributions and generally unreliable membership statistics. In the first years of the reform, the initial increase in coverage occasioned by the inclusion of the entire family unit and the slow penetration of private competition translated into soaring profit levels for the EPSs, which enabled the corporate ISS to continue expanding its staffing table and invest heavily in IPS infrastructure. Although the EPSs and the IPSs were created as separate business units, the IPSs continued to draw their funding from historical budgets, with no explicit link between financing and performance. This situation prevented the EPSs from monitoring expenditures effectively or accurately.

1.27 As time passed, the regulatory framework for the system made it necessary for the EPSs to rely entirely on UPCs as a source of revenue based on an objectively prepared tally of plan members. The shrinkage of the EPS-ISS' market share drove revenues down sharply. However, the rigidity of these institutions' fixed cost structure, owing to the expansion of IPS staff and infrastructure, has prevented them from adjusting expenditures in line with this lower level of revenue. The IPSs have maintained their historical budgetary structure, with no more than marginal cutbacks, and as a result of the misalignment between supply and demand, increasing amounts of services are going unused. This is especially the case in medium-sized cities or urban areas that have traditionally had excess installed capacity. This lack of synchronization between the EPSs and the IPSs has caused them to run operating deficits and to register reductions in their net asset positions for the past five years.

1.28 *Payroll expenses and financial performance*. The rigidity of IPS expenditures is primarily a result of the regulations governing its employment procedures. Most of its employees are classified as civil servants, and the benefits package provided for in the collective agreement that therefore applies to ISS personnel has a cost ratio of 43.7%, as compared to an average nationwide ratio of 21%.[8] ISS employees are also entitled to a special retirement package that allows them to retire five years earlier than the rest of the population and to receive differential benefits, which the ISS must pay out of its own resources. The ISS has never (either before or after the reform) set up a fund to cover the rising level of liabilities generated by its employees' special retirement benefits. The number of retirees will have jumped from 14,097 in 2000 to 23,212 by 2012; this increasing burden on ISS finances will amount to approximately 30% of its operating revenues, rendering EPS operations

[8] The benefits cost ratio is calculated on the basis of the total number of days attributed to a worker per year for purposes of the basic allowance, services rendered, vacation days, vacation allowance, seniority benefits, and severance pay.

entirely unsustainable. The Colombian government has agreed to cover the cost of benefits for persons who retired before 1993, but this group represents a negligible proportion of total retirement expenses and remains constant in size; this agreement therefore resolves only a small fraction of the cash flow problem and does not address the structural issue.[9]

1.29 Declining revenues and the lack of a sufficient culture of financial discipline, in combination with the rigidity of expenditures and a misguided commercial policy, have triggered a serious deterioration in the quality of health care services. As a result of these problems, the EPSs have lost their dominant position in the market. Between 1997 and 2002, the EPSs lost over half of their members, and the desertion rate has risen since 1998, when EPSs were sanctioned by the National Health Superintendency for failing to meet minimum financial and health-care performance standards and were ordered to suspend the registration of new members. Between 1999 and 2002, a growing operating deficit reflected the fact that, for each peso of revenue, 1.7 pesos were being spent. The deficit, which was financed by central government contributions of approximately US$200 million per annum in 2001 and 2002, is chiefly attributable to the decline in membership and, hence, in revenues.[10]

1.30 In view of this situation and the fact that, in the immediate future, EPS membership will not only fail to rise but will continue to follow the declining trend seen in recent months (during which membership has been decreasing at a rate of 50,000 per month), it is clear that revenues will continue to shrink. Given the rigidity of the payroll and the rigidity of expenditure levels, the existing financial imbalance will only grow worse, and the cumulative deficit is projected to reach 3.3% of GDP by 2012. The accumulated deficit not only places a burden on central government accounts but also blocks any expansion in the subsidized system's coverage and therefore represents an increasingly serious obstacle to the achievement of the objectives of equity provided for in Act No. 100 of 1993.

6. Family Allowance Funds

1.31 Created in 1957 in order to assist low-income workers and their families, the Cajas de Compensación Familiar [Family Allowance Funds] (CCFs) are private organizations whose revenues are provided by a quasi-fiscal contribution equivalent

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[9] The available statistics indicate that the EPS is covering 80% of the payments made to retirees in 2003, but this figure will have descended to 52% by 2005. The proposal, which is included in the referendum, to do away with these special retirement packages would lighten the operational burden and reduce the institution's liabilities.

[10] The US$200 million in financing provided by the government was furnished under an agreement with the ISS which requires this institution to adopt a number of measures and meet a set of performance benchmarks. An examination of these commitments reveals that they were based on entirely unrealistic expectations, and the ISS therefore failed to meet the great majority of these targets.

to 4% of total wages. Workers in the formal sector of the economy are eligible for benefits only so long as they are paying their contributions. There are 55 CCFs in 32 departments, with a membership of approximately 3.5 million formal-sector workers (23.8% of the economically active population). The CCFs are legally obligated to provide cash subsidies, housing subsidies, health care, educational services and childcare benefits to their members, but they also allocate funds for marketing, food programs, libraries, recreation, training, and other services.

1.32 Mandated CCF allocations for the subsidized health care system are not targeted at CCF members, since this system does not cover formal-sector wage earners, who belong to the contributory health care system instead. The EPSs and the CCF Administradoras del Régimen Subsidiado [Subsidized System Administrators] (ARSs) are open to all workers in the contributory system, and to all members of the subsidized system who meet the established requirements. According to figures provided by the National Health Superintendency, as of 1998, 1.5 million persons were signed up with the CCFs' ARS. A total of 41 Funds have set up ARS in 516 municipalities throughout the country.

1.33 Although the CCFs are regulated by the Family Allowance Superintendency and the National Health Superintendency and are required by law to meet certain resource allocation and accounting standards, some CCFs have been unable to do so. Some also have problems relating to corporate practices. The government is implementing a series a reforms to improve resource allocation, particularly as regards administrative expenses, and to foster greater corporate responsibility and accountability. These include: (i) establishing effective channels for disseminating information on the appointment or removal of legal representatives and other directors; (ii) setting up mechanisms whereby a minimum number of members can request that a special meeting be convened; (iii) eliminating the skewing of CCF membership that leads to adverse selection in the market; (iv) enhancing member mobility or withdrawal by simplifying procedures; (v) standardizing the CCF accounting report format; and (vi) putting an end to the collusive practices of some CCFs.

D. The country strategy as it relates to the SGSSS

1.34 As part of the National Development Plan, the government plans to: (i) *strengthen the health care insurance system* by expanding coverage, shifting from supply-side to demand-side subsidies, reorganizing the public hospitals, and upgrading registration, information, and collection systems; (ii) *ensuring the SGSSS' financial sustainability* by monitoring and making annual adjustments in the UPC and the benefits plan, reviewing the methodology used to accredit or organize insurance companies, and establishing, inter alia, conditions conducive to the continued operation of the system; (iii) *improving service delivery and access* by regulating entry mechanisms for service providers, creating systems for evaluating and monitoring supply and demand, setting up a consolidated fee schedule, and

providing incentives for improvements in efficiency and quality; (iv) *implementing priority public health measures* such as executing an expanded vaccination program, implementing the reproductive health policy, providing insurance for maternal and child health care, and conducting disease and risk prevention programs; and (v) *restructuring the ISS* in order to make it financially viable.

E. The Bank's strategy and the program's contribution

1. The Bank's strategy

1.35 The *Bank's strategy with the country* (BSC) establishes three main lines of action for 2003-2006: (i) laying the foundations for reactivating and galvanizing the economy; (ii) promoting social development and providing protection for the most vulnerable sectors of the population, and (iii) enhancing governance and supporting State reforms. The BSC also identifies two major constraints: the fiscal deficit, and the escalation of the conflict in the country. The gradual resolution of these two constraints is an underlying assumption upon which the strategy's success in terms of the main BSC lines of action is based.

1.36 In terms of the main BSC lines of action, this operation will primarily contribute to the second objective. By supporting efforts to reform the health care system and restructure the ISS, it will contribute to the provision of financially sustainable social services that will cover the population's needs more effectively and make more efficient use of available resources. At the same time, by helping to strengthen the ISS and enhance the transparency of the CCFs, it will be contributing to the achievement of the third objective. In addition, the steps to be taken to place the ISS and public hospitals in a stronger financial position, which will in turn contribute to an improvement in national finances and financial accounts at subnational levels, will help to mitigate the constraints associated with the fiscal deficit. Within the framework of the stand-by arrangement (SBA) reached with the International Monetary Fund (IMF), the loan proceeds are also included in the external credit disbursement program prepared by the Ministry of Finance and Public Credit for 2003-2005.

2. Bank support for health care reform

1.37 As noted in the BSC, structural changes and institution-strengthening in any sector take time. A great deal of experience has been gained in the health care sector, and the Bank's presence and support have ensured the continuity of the reform process and have helped in setting intermediate goals to be met as work toward the long-term objective proceeds. Through five different operations designed and executed over the past 10 years, the Bank has been the multilateral agency most closely involved in this process. Emphasis has been placed on supporting the provision of access to health care for the lowest-income groups by means of reforms or direct financing. The main areas of activity have been: (i) registration of members in the

subsidized and contributory systems; (ii) welfare assistance for the elderly and for minors in low-income households; (iii) modification of formulas and guidelines for transfers to subnational units; (iv) pilot projects dealing with the structural reorganization of public hospitals; (v) coverage for vaccination costs; (vi) regulations aimed at improving SGSSS management; and (vii) initial ISS reforms. The present operation provides continued support for the reform initiatives being pursued by the government under the National Development Plan and for achievement of the goals and structural reforms provided for in the SBA. Table I-1 provides an overview of the support provided by the Bank in the health care sector, the outcomes of those activities, and the lessons learned.

Table I-1. OVERVIEW OF BANK SUPPORT ACTIVITIES IN THE HEALTH CARE SECTOR

Title	Activities or conditions	Outcomes	Lessons learned
Health Services Improvement Program (716/OC-CO) *Completed*	Improvement of public hospital management prior to and during the reform process. Pilot project for reorganizing and strengthening management systems in a sample group of public hospitals.	Contribution to the sustainability of hospital services by converting the hospitals into ESEs, introducing management and administrative procedures that were unknown prior to the implementation of the reform process, and converting supply-side subsidies into demand subsidies. Significant increase in the efficiency of the health care services provided in the hospitals included in the pilot project.	The project did not modify structural conditions in any of the public hospitals except those that were included in the pilot project; this diminished the chances of success for the program as originally designed.
Health Reform Support Program (910/OC-CO) *In progress*	Research and activities aimed at contributing to the achievement of the objectives of the social security health care system in terms of universal coverage, equitable access, institutional efficiency, and quality of service. Pilot project for reorganizing and strengthening management systems in a sample group of public hospitals, cofinanced by the Health Services Improvement Program	The research financed by the Bank has focused on key aspects of the reforms, and the findings have been incorporated into legislation concerning policies, institutions, and human resources in the sector. The program has also contributed financing for the pilot project on the reorganization of public hospitals, which resulted in a significant increase in the efficiency of health care provision in the hospitals included in the project.	Project implementation has been hampered by the pace of health care reform program, since the two are so closely intertwined.
Subnational Fiscal Reform Program (1265/OC-CO) *Completed*	Modification of the formulas used for calculating transfers to subnational units for health care. Definition of areas of responsibility in the field of health care for the national government and subnational institutions. Structuring and reduction of a portion of pension liabilities at the subnational level.	The growth of transfers was brought under control. Basic standards and regulations for the definition of areas of responsibility were established. Foundations were laid for the introduction of measures to deal with liabilities at the subnational level.	Major reforms can be achieved with a policy-based loan (PBL). Because of the lead times involved in the passage of legislation, however, the development of the more detailed aspects of the regulations underpinning the reforms will need to

Title	Activities or conditions	Outcomes	Lessons learned
			be continued in subsequent operations.
Social Reform Program (1381/OC-CO) *Completed*	Expansion of subsidized system. Management procedures and progress in the application of partial subsidies at the subnational level to provide insurance for poor workers able to make some sort of contribution. Protected expenditure and vaccination benchmarks for 2002.	Subsidized system expanded (an additional 300,000 persons). Regulations were approved, but had little impact in expanding insurance coverage. Expenditures were made as agreed; average vaccination rate for selected diseases was raised from 77% in 1999 to 82.6% in 2002.	A PBL can contribute to the achievement of coverage targets in key programs. Fiscal constraints at the subnational level and the hospitals' structural problems prevent insurance coverage from being extended to cover the entire target population, above and beyond the objective set by the program.
Social Emergency Program (1455/OC-CO) *In progress*	Protected expenditure and vaccination benchmarks for 2003. Management and target-setting for the introduction of a quality control system in the SGSSS. Management and target-setting to shorten ARS-provider processing times in the subsidized system.	Expenditure allocation and spending as agreed. Coverage targets to be reported at end-2003. 23 IPSs, EPSs and ARSs in the process of securing accreditation under the new system. Reduction in processing times between charge and reimbursement in the SGSSS from 167 to 110 days.	Emergency operations are effective tools for ensuring the continuity of social reform processes during periods when fiscal constraints are a problem.

F. The Bank's experiences and the lessons learned

1.38 The Bank's experience with fast-disbursing loans in Colombia can be summed up as follows: (i) the loan proceeds serve as an efficient countercyclical tool; (ii) these operations have helped carry reforms forward, especially in the financial sector at the subnational level, which have played a vital role in eliminating one of the main causes of the crisis in the private sector and of the nonfinancial public-sector deficit; (iii) a combination of emergency and policy-based lending (PBL) operations is an efficient approach because the former provides funding to cover short-run fiscal requirements while the latter supports the reforms needed to eliminate the underlying imbalances; and (iv) although the emergency operations have had a considerable impact on the repayment profile for 2003-2004 and may influence the 2005-2006 schedule as well (especially in terms of payments to the Bank), the timing of these operations and the reforms they supported were necessary in order to avert a more serious crisis in Colombia.

1.39 Three major lessons have been learned about the design and execution of these operations: (i) the importance of enlisting the active participation of sectoral agencies and ministries responsible for matters relating to conditionality, since their involvement is needed in order to define feasible policy conditions and arrive at performance commitments; (ii) coordination with other multilateral institutions in

dividing up issues or areas of reform allows each institution to provide greater support to the country; and (iii) the Bank's support for reforms in areas central to the government's operations have had a highly significant impact on financial, social, health care, and subnational sectors.

G. Coordination with other multilateral agencies

1.40 The effort to backstop Colombia in terms of both its reform programs and the provision of financing is being closely coordinated with other multilateral agencies and the Colombian government. As part of the reform effort, the IDB and the World Bank are working together to protect social expenditure levels. There is a possibility that the World Bank will provide financing to assist with the rationalization of the country's public hospitals, and the SBA negotiated with the IMF has provided a frame of reference for the US$7.349 billion in financial commitments by multilateral agencies that have been approved for 2003-2006. Of this amount, approximately US$4.7 billion will be in the form of fast-disbursing funds (53% to be approved in 2003). The government's financial program for 2003 provides for estimated total disbursements of US$2.51 billion from multilateral agencies, with 56% of this amount coming from the IDB.

II. THE PROGRAM

A. Objectives and description

2.1 The program's objective is to backstop the government's efforts to improve the coverage, quality, equity, and financial sustainability of the social security system's health care component over the medium term.

2.2 Actions in the following four areas will be conditions precedent to the release of the program's disbursements: (i) compliance with macroeconomic policy guidelines; (ii) financial sustainability and efficiency of the subsidized regime administered by the SGSSS; (iii) financial sustainability and efficiency of the ISS; and (iv) efficiency, transparency, and equity of the CCFs. The policy matrix, which sets out the conditionality requirements associated with each of these areas, is shown in Annex I, while the means of verification to be used in determining fulfillment of these conditions are outlined in Annex II. The policy letter outlining the program is attached as Annex IV.

B. Structure

1. Component A: Macroeconomic stability

2.3 This component's objective is to ensure that the macroeconomic environment is in keeping with the program's objectives. Satisfaction of this condition will be established for each tranche in a report to be prepared by the Consejo Superior de Política Fiscal [Supreme Council on Fiscal Policy] (CONFIS) on the macroeconomic status of the borrower. The report will include, inter alia, the findings of the latest performance review of the SBA negotiated with the IMF (*conditions 1 and 2*).

2. Component B: Efficiency and financial sustainability of the subsidized SGSSS system

a. Objective

2.4 This component's objective is to increase coverage, the quality of care, and equity in resource allocation for the poorest groups, and to build a sustainable financial foundation for the health care system. To achieve these objectives, the program will support measures aimed at modifying the subsidized health care system, rationalizing the public hospital system, promoting measures to improve the information system with a view to reducing SGSSS evasion and avoidance, and altering the POS-UPC monitoring and adjustment methodology.

b. Conditions

2.5 *Subsidized health care system.* The aim here is to maintain the growth trend in coverage. For the first tranche, the government has pledged to expand the subsidized health care system's coverage (320,000 between June 2002 and June 2003) (*condition 3*). For the second tranche, verification is to be provided of the expansion of the subsidized health care system's coverage by 800,000 between July 2003 and the end of 2004, with 600,000 of these new memberships to be financed by the SGP and the other 200,000 spots to be freed up by screening the list of persons currently registered with the subsidized system (*condition 4*).

2.6 *Public hospitals*. The aim is to support the government's efforts to revise the standards and regulations that are currently hindering the conversion of supply-side subsidies into demand subsidies with a view to expanding the subsidized health care system and to backstop measures for eliminating the public hospitals' financial imbalances. These modifications will focus on reducing discounts (particularly the SGP discounts for health care) and the payrolls of public hospitals (in tandem with the financial adjustment and modernization of the hospital system).

2.7 For the first tranche: (i) the regulations and standards that will shape the policy on the reduction of supply-side subsidies at the departmental level will have been approved; (ii) no transfers are to have been made by the central government to public hospitals to finance any services for which delivery targets have not been set; (iii) 18 public hospital structural reorganization agreements are to have been signed; and (iv) the government will have approved a plan for restructuring the public hospitals, in addition to the agreements specified in point (iii). The objective of this last measure is to achieve a 20% supply-side reduction in expenditure for the hospitals undergoing structural reorganization while maintaining service portfolio and quality at aggregate delivery levels consistent with demand (*condition 5*).[11]

2.8 For the second tranche, the government has pledged to: (i) approve an action plan to identify methods of payment other than direct transfers for use by subnational units in compensating public or private IPSs; (ii) approve and implement a plan of action for redirecting supply-side subsidies to promote the expansion of health insurance coverage; (iii) not make any transfers from the central government to public hospitals to finance any services for which delivery targets have not been set; (iv) work toward achieving the benchmark objectives established in the 18 hospital agreements; and (v) work toward achieving the objectives established in the public hospitals' structural reorganization agreements, including the rationalization of supply and hospital consolidation (*condition 6*).

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[11] The cost of restructuring the 18 public hospitals described in point (iii) will be covered with the government's own resources. The cost of the structural reorganization plan mentioned in point (iv) will be financed with the government's own resources and funding from the Health Care Reorganization, Redesign, and Modernization Program (CO-0139), which is now in the preparatory stage.

2.9 *Reduction of evasion and avoidance within the SGSSS*. For the first tranche, the government has pledged to design a reporting system to aid in developing means to control evasion and avoidance (*condition 7*).[12] For the second tranche, verification will be required of satisfactory progress in the implementation of the reporting system and toward achievement of the targets set for the control of evasion and avoidance (*condition 8*).

2.10 *Plan Obligatorio de Salud [Mandatory Health Plan] (POS)*. In working to build a system for the ongoing monitoring and adjustment of the POS and UPC as a means of ensuring the cost-effective operation and financial equilibrium of the SGSSS, for the first tranche the government will document the progress made in designing a methodology for the regular review and updating of the contents and costs of the POS-UPC. In so doing it will take into account the relevant fiscal constraints and the cost effectiveness of the measures to be financed, as well as setting a timetable for their implementation (*condition 9*).[13]

2.11 For the second tranche, the government commits itself to: (i) secure approval for legal provisions that will permit the modification of the POS-UPC so that the value of the UPC or the content of the POS can be adjusted year by year so as to maintain the financial balance and the cost effectiveness of the services provided; and (ii) undertake the first technical evaluation based on the POS-UPC monitoring and assessment methodology (*condition 10*).

3. Component C: Efficiency and financial sustainability of the ISS

a. Objective

2.12 The objective of this component is to ensure the financial sustainability of the ISS over the medium and long terms and to improve the quality of service. Since its present lack of viability is a function of both organizational/operational and structural factors, the reform effort is directed toward arriving at solutions in both of these areas by combining measures that will have an immediate impact with others that will have sustained effects over the long term.

b. Conditions

2.13 The core component of the reform initiative as it relates to organizational/operational issues is the effective division of the EPSs and the IPSs so that their financial relationship (as manifested in contracts and prices) can be based on a clearly defined link between financing and services rendered. These reforms include the conversion of the existing IPSs into a cluster of seven ESEs to

[12] The design and implementation of this system will be financed by the Health Reform Support Program (910/OC-CO).

[13] This monitoring system is to take ethnic variables into account.

be overseen by the Ministry for Social Welfare. The present EPS will continue to form part of the ISS, together with the Pension Administration Board (AP) and the Occupational Risk Administrative Board (ARP).

2.14 In terms of the immediate structural impact of this reform, the new ESEs will have to streamline their installed capacity and support staff in order to align the services they offer with existing demand on the part of the EPS-ISS or other EPSs and ARSs in the country. ESEs will be contracted primarily by the EPS-ISS over the next three years; after that period, they will have to compete in the market, and only those that are able to cover their expenses with their own resources will survive.[14] The EPS-ISS will contract the ESEs at the prevailing rates that it charges other public and private service providers. The contracts will set out indicators and minimum standards for service quality (nosocomial infections and in-hospital mortality rates, among others) and for the timing of service delivery (average waiting time for appointments with general practitioners, specialists, and surgeons). This way, if insurmountable difficulties should arise with the ESEs, it can choose to contract other providers in order to survive in this highly competitive market. This is especially important in view of the fact that inefficiency and other problems inherited from the past have hampered efforts to halt the decline in membership and eventually regain some of the ground that has been lost.

2.15 Over the long term, the structural reorganization will alter the employment conditions of most of the workers, as they will cease to be covered by the current collective labor agreement. This change will partially resolve the problem posed by the growth of pension liabilities and the employment rigidities discussed earlier. Once the institutional division has taken place, the EPSs will absorb the payments for all retirees covered by the preferential system and for most of the unionized civil servants covered by the collective labor agreement. The Ministry of Finance and Public Credit has promised to assume payment obligations for persons who retired prior to 31 December 2001 starting in fiscal year 2005. This will provide the EPS-ISS with the financial and institutional leeway needed to design operational means of expanding its membership coverage, boosting revenues, and achieving medium- and long-term financial stability.

2.16 For the first tranche, the government has committed itself to: (i) securing approval of the legal provisions required to restructure the ISS by effectively separating the EPSs and the IPSs; and (ii) submitting an action plan for the restructuring of the EPS-ISS and the ESEs (*condition 11*). For the second stage of the reform process, the government will make substantive progress toward fulfilling the action plan agreed upon during the first stage (*condition 12*).

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[14] It should be noted, however, that during this three-year grace period, the central consideration in EPS contracting will be the actual demand that has been generated, rather than the available supply-side subsidies. This means that very careful planning and rationalization of supply will be required of the boards of directors of the newly created ESEs.

4. Component D: CCF efficiency, transparency, and equity

a. Objective

2.17 This component's objective is to create institutional mechanisms for ensuring transparency, accountability, and greater equity at CCFs.

b. Conditions

2.18 For the first tranche, the government will establish the regulatory framework for maintaining transparency and accountability for the CCFs, as specified in Act No. 789 of 2002, and approve an action plan for implementing it. The government will also enact regulations to bring monetary subsidies into line among CCFs in the various regions and set targets for their implementation (*condition 13*). For the second tranche, it will be determined whether satisfactory progress is being made on the action plan described in condition 13 and on meeting the targets for implementing monetary subsidies (*condition 14*).

C. Cost and financing

2.19 The total cost of the program amounts to US$400 million; this sum is to be disbursed in two tranches (US$250 million in the first and US$150 million in the second) in accordance with the policy matrix shown in Annex I.

D. IDB loan terms and conditions

2.20 The US$400 million to be provided by the Bank will be drawn from the OC funds. The terms and conditions for this loan are shown in Table II-1.

Table II-1. LOAN TERMS AND CONDITIONS

Funding source:	Ordinary Capital (OC)
Amount:	US$400 million
Periods:	
Amortization:	20 years
Grace:	5 years
Disbursement:	18 to 36 months
Interest rate:	adjustable
Inspection and supervision:	1%
Credit fee:	0.75% of undisbursed sums
Currency:	US dollars drawn under the Single Currency Facility

III. PROGRAM IMPLEMENTATION

A. Implementation

1. Borrower and executing agency

3.1 The borrower will be the Republic of Colombia. The Ministry of Finance and Public Credit, acting through its Viceministerio Técnico [Office of the Deputy Minister for Operations], will serve as the executing agency.

2. Program implementation and administration

3.2 The executing agency will be responsible for the program's overall supervision and for ensuring the timely achievement of its objectives and goals. These activities will be carried out in coordination with the Departamento Nacional de Planeación [National Planning Department] (DNP). The Ministry for Social Welfare and the ISS will be responsible for ensuring the fulfillment of the conditions and implementation of the reform measures associated with each program component. An inter-ministerial task force composed of representatives of each of the corresponding organizations will be set up in the Ministry of Finance and Public Credit to coordinate and monitor the program. The task force will be headed up by a general coordinator, to be designated by the Ministry of Finance and Public Credit, and by coordinators named by each of the corresponding organizations.

3.3 The duties of the general coordinator will be to: (i) serve as the central government's liaison with the Bank and, as such, take responsibility for compiling and forwarding the technical, legal, and administrative information required for each disbursement; (ii) provide support for fulfillment of each of the conditions established for the various program components; (iii) coordinate program activities and reforms with the designated personnel in each organization; and (iv) coordinate the collection and submission of the supporting information regarding fulfillment of the conditions set forth in the policy matrix.

B. Monitoring and evaluation

3.4 *Monitoring*. The Ministry of Finance and Public Credit and the DNP will monitor fulfillment of the conditions on a semiannual basis and to prepare an annual evaluation of performance in this regard. These outputs are indicated in the government's National Development Plan for 2002-2006. The monitoring activities are intended to help increase the effectiveness and coordination of State policies, programs, and institutions. The findings will be set out in semiannual reports to the Bank covering the progress made and the challenges that arise during the implementation of the program's policy measures. This information will also be

posted on the DNP web page. This will make it possible to arrange for results-based management by sector as well as facilitating oversight by civil society.

3.5 *Evaluation*. Annex III summarizes the output and outcome indicators to be measured over time as a way of assessing how effectively the reforms accomplish their objectives. It lists baseline values, targets to be met six to twelve months after the last disbursement, and medium-term targets to be met three years after the last disbursement of the sector loan. These indicators have been chosen for their direct relationship to the program activities.[15]

3.6 The authorities have told the project team that they would prefer not to finance an ex post evaluation of the program. The government has, however, made a commitment to ensure that the information necessary for a final evaluation of the outcome indicators is made available three years after program end.[16]

C. Other implementation issues

1. Implementation period and disbursement timetable

3.7 The minimum implementation period is 18 months and the maximum is 36 months. The conditions precedent to the first tranche will be fulfilled when the loan proposal is submitted to the Board for its consideration.

3.8 The deadlines for completion of the reforms listed in the policy matrix are important because of: (i) the scale of the reforms to be supported by the program, especially the structural reorganization of the hospital system and the ISS; (ii) the level of own resources (or borrowings) that the government is allocating for the purpose of putting the hospitals' finances in order; and (iii) the existence of a political environment that is conducive to change and reform. If the reforms are carried out within the timeframes agreed upon with the government: (i) the coverage of the social security system's health care component will have been expanded and the quality of the care provided will have been improved within a fairly short span of time; (ii) the expected fiscal savings will have been achieved, thereby justifying the government's initial outlays; and (iii) the probability that the reforms will be irreversible will have increased.

3.9 Given the importance of completing the reforms within the specified timeframes, the second tranche will be contingent upon the progress made. Consequently, no

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[15] Note that the evaluation is designed in such a way that measured changes in the indicators may not necessarily be attributable to the program activities.

[16] Given the sophistication of the development indicator monitoring and evaluation system and the investment to be made in the Sistema Integral de Información en Salud [Integrated Health Care Information System] (SIIS), the government has already absorbed much of the cost of indicator documentation, compilation, and reporting.

fixed deadline has been set for the fulfillment of key conditions (especially those relating to the public hospitals and the ISS); instead, attainment of the cumulative annual targets for the financial, operational, quality, and delivery indicators will be required before the second tranche will be disbursed.

2. Policy letter

3.10 The country and the Bank have agreed upon the terms of a policy letter which sets the program within the wider framework of the government's economic and social strategy (see Annex VI).

3. External auditing

3.11 The Bank reserves the right to request that the borrower submit financial reports on the use of loan funds. These reports are to be verified by independent auditors accepted by the Bank beforehand. The borrower therefore agrees to: (i) keep separate accounting records and supporting documentation providing the necessary information for the preparation of external audits and/or for verifying the use made of the loan proceeds; and (ii) maintain a separate bank account in which the loan funds will be deposited.

4. Inspection and supervision

3.12 The Bank will establish the inspection procedures it deems necessary for the satisfactory execution of this operation. To that end, the borrower will cooperate with the Bank by providing the required assistance and information.

IV. VIABILITY, IMPACTS AND RISKS

A. Institutional viability

4.1 In implementing this program, the Ministry of Finance and Public Credit will act as the executing agency and will work in close coordination with the DNP, the Ministry for Social Welfare, and the ISS, which will be responsible for carrying out the reforms outlined in the policy matrix. The program's viability (the feasibility of fulfilling the specified conditions within the implementation period) is based on three elements: (i) the relevant institutions' experience in working with the Bank; (ii) the human and financial resources needed to carry out the reforms; and (iii) the existence of incentives for the program's implementation.

4.2 With respect to the issue of experience in working with the Bank, both the Ministry of Finance and Public Credit and the DNP have worked together on five PBL and emergency operations in the past five years. With the exception of one of those operations, all the conditions were fully met within the stipulated timeframes. The Ministry for Social Welfare is currently serving as the executing agency for an investment operation (Health Reform Support Program (910/OC-CO)) and is responsible for meeting various conditions for the Social Emergency Program (1455/OC-CO). The ISS does not have past experience in working with the Bank, but it has received a great deal of support from the DNP and the Ministry for Social Welfare during the preparation of this operation.

4.3 With regard to the required human and financial resources, it should be noted that part of the research and preparatory work on the action plans for the health component are being financed by the government. A number of specific support activities (assessment of the CCFs, information systems for the ISS and the ESE, and the study on the POS-UPC) are being financed with administrative Bank resources. In addition, all the relevant institutions have assigned personnel to the project who have been working on it since the initial preparatory stages of the operation were begun and who will continue to do so as members of the inter-ministerial task force mentioned in paragraph 3.2.

4.4 Incentives for fulfillment of the operation's conditions by the sector-specific institutions (the ISS and the Ministry for Social Welfare) are related to their budgetary allocations in the case of the hospital reform program and the ISS' pension liabilities. The ISS also has an incentive to make sure that the split with the ESEs works out because its own financial viability for the next three years will be determined by the outcome of that initiative. In the case of the Ministry for Social Welfare, the ESEs will complement the hospital rationalization process.

B. Expected outcomes

4.5 The objective of the component dealing with the efficiency and financial sustainability of the subsidized SGSSS system is to increase SGSSS coverage, improve the quality of care, and achieve greater equity in the allocation of the system's resources in order to benefit the poorest sectors of the population. By expanding the subsidized health care system's coverage, reducing direct supply-side subsidies for public hospitals, and taking steps to boost the public hospitals' efficiency in terms of service delivery, it is hoped that a significant increase in health insurance coverage can be achieved as a direct result of the conditions stipulated by the program and as an indirect result of the reallocation of funds from supply subsidies to health insurance. This expansion of the subsidized system's coverage of the poorest and most vulnerable sectors of the population will also contribute to more equitable resource allocation on the part of the SGSSS. As the conditions stipulated by the program are also designed to improve the quality of the health care provided by public hospitals and the new ESEs (which were previously ISS clinics), improvements in the quality of services rendered will also be measured. The baseline indicators and targets delineated in Annex III will be used to measure these outcomes.

4.6 Through the component dealing with the efficiency and financial sustainability of the ISS, the program will backstop policy measures designed to give that institution financial stability by halting the growth of its retirement pension liabilities, splitting the IPSs up into ESEs in order to reduce the associated labor cost rigidities, endowing the EPS-ISS with the necessary institutional conditions to reverse the downturn in its market share, and augmenting the transparency of the financial relationship between the EPS-ISS and the ESEs so that financing will be provided only for those services that are actually in demand while ensuring that those services are of acceptable quality. This re-engineering of the system is aimed at restoring a stable operating ratio for the EPS-ISS and eventually mitigating these imbalances' impact on the country's fiscal situation. Thus, by the end of the three-year period, the EPS-ISS will have brought its spending levels into line with the revenues generated by its members and will no longer be running a deficit. In addition, the conversion of the IPSs into ESEs will do a great deal to curb the growth of pension liabilities and will permit the ESEs to align the size of their operations and their payrolls with the actual demand for their services. The baseline indicators and goals listed in Annex III will also be used to measure these outcomes.

4.7 The component dealing with the efficiency, transparency, and equity of the CCFs will help these organizations to increase their accountability. In addition, the regulation of CCF monetary subsidies will make it possible to even out the benefits received by CCF members across different regions of the country.

C. Net fiscal impact

4.8 For the ISS, the baseline scenario projects the deficit/surplus position of the ISS from 2004 to 2007 under the assumption that no restructuring takes place and that, consequently, no adjustments in revenues or expenditures are made, with its membership remaining constant at 2.7 million persons. The reform scenario assumes that the EPS clinics and other out-patient facilities will be split off and that the planned changes will be made in the benefits and entitlements of most of the ISS personnel who will have been transferred to the new ESEs (i.e., the great majority of such staff will be shifted from the civil servant plan to the public–sector employees' plan). The main source of savings made possible by this division, which will be reflected from 2004 on, will therefore be adjustments in payroll expenses and, to a lesser extent, improvements in the management of the ESEs.[17] In addition, the reduction in the total expenditures of the public hospitals included in the reform plan is estimated at 20% on average. The results of these measures are shown in Table IV-I.

Table IV-I. ESTIMATED FISCAL SAVINGS

Fiscal savings		2004	2005	2006	2007
Division of ISS	US$million	62.0	53.0	41.6	37.0
	%GDP	0.07	0.05	0.04	0.03
Rationalization of hospitals	US$million	49.6	65.2	84.2	136.9
	%GDP	0.05	0.07	0.08	0.12

4.9 The net fiscal impact of the reforms, if the rationalization of the health care system goes ahead, will take the form of rising levels of savings as these measures are implemented in an increasing number of hospitals. The net savings generated by the reforms will climb from 0.05% of GDP in 2004 to 0.12% of GDP from 2007 on. The structural reorganization of the ISS is expected to generate immediate savings for the central government equivalent to 0.07% of GDP in 2004, after which they will gradually diminish.

D. Social and environmental impact

4.10 *Social equity/poverty-targeted investment classification*. In terms of its social impact, the program is expected to help make the distribution of benefits more equitable, improve the quality of care, and expedite service delivery. The rationalization of the public hospital system will lead to an expansion of service coverage, with emphasis on lower-income groups. The program therefore qualifies as a social equity enhancing project. On the other hand, in view of the guidelines

[17] It should be stressed that the reform scenario does not consider the possibility that the reforms subject to referendum will be approved and it therefore does not include the savings that would be generated by the discontinuation of the special systems and exemptions.

for the design of policy-based lending operations, it does not qualify as a poverty-targeted investment (PTI).

4.11 *Social and environmental impacts*. Because of the special nature of this program, it does not entail any physical or other investment projects and will therefore have no direct environmental impact. In order to serve indigenous and Afro-Colombian minorities, the program will include this ethnic variable in the ongoing POS adjustment and monitoring system and will give priority to indigenous groups in allocating health care subsidies.

4.12 In addressing this last issue, the program will seek to uphold, implement, and ensure compliance with Act No. 691 of 2001 on the participation of ethnic groups in the SGSSS. In addition, under the terms of CNSSS Agreements Nos. 77 of 1997 and 244 of 2003, persons who, by reason of their poverty and vulnerable status, are unable to pay for membership in the contributory system shall enjoy priority access to the benefits of the subsidized health care system. The SGSSS generally uses the Sistema de Clasificación de Beneficiarios de Programs Sociales [Social Program Beneficiary Classification System] (SISBEN) as a targeting mechanism for these purposes, but in the case of poor persons belonging to indigenous groups, it uses the census roster which the relevant indigenous authority is responsible for drawing up and keeping up to date. Furthermore, among all the people whose incomes are sufficiently low to allow them to qualify for subsidies, Agreement No. 277 confers priority to indigenous groups.

4.13 The Health Care Reorganization, Redesign, and Modernization Program (CO-0139), which is currently in the preparatory stage, will finance activities designed to improve and monitor the handling of waste materials in the country's hospitals in order to keep the risk to which health care workers are exposed to a minimum. This same program will also finance technical assistance for the implementation of a vocational training and retraining program for persons whose employment status is threatened by the structural reorganization of the staffing table.

E. Risks

4.14 The main specific risks are as follows:

a. There is a political risk entailed in any slowing of the pace of the reforms, their deferment, or reversal, especially in the case of the ISS and the public hospitals. *Mitigation*: The most important decisions regarding how to split up the ISS—in relation to both the issuance of regulations and specific measures for setting up the hospitals as new ESEs—were made during the program's preparatory phase. This is indicative of the government's firm commitment to reform (Ministry of

Finance and Public Credit, MPS, and ISS).[18] Semiannual monitoring of the program will permit any sign of diversions or deviations in the ISS structural reorganization process to be identified in time. As for the hospitals, an interest in improving the services they provide is shared by the central government, authorities at subnational levels, and users of the system. The pilot project has shown that the reactions of the groups who will be affected by the rationalization measures (ESE employees) can be coped with, provided that the hospitals maintain or improve the quality of care and that they provide compensatory payments and retraining programs for the personnel affected by these measures. Both elements are an integral part of the plan for restructuring the hospitals, and availability of the fiscal capacity required for the corresponding actions during the implementation period has been ensured. As in the case of the ISS, semiannual monitoring will be very important in assessing and mitigating this risk. Lastly, it should be noted that Colombia has a record of fulfilling the commitments and conditions set in emergency operations and PBLs.

b. The legal vulnerability of the POS-UPC is an ongoing challenge in terms of the financial equilibrium of the SGSSS. *Mitigation*: Historical evidence shows that the number of petitions for preventive injunctions to protect constitutional rights, filed against public utilities, is directly related to service quality. In the health care sector, structural reorganization of hospitals will improve quality and coverage, resulting in fewer such actions being brought. The government is also looking into the possibility of creating a specialized judiciary to rule on matters relating to SGSSS legislation, which would be better equipped to strike a balance between individual and societal rights as they relate to health care services.

c. Availability of the fiscal capacity required for the structural reorganization of public hospitals, especially in 2004, is another concern. *Mitigation*: The preliminary draft of the 2004 budget that has been sent to Congress includes the line item necessary for the hospitals to begin restructuring. The availability of funding for subsequent years will largely depend on how the fiscal situation evolves.

d. Conditions conducive to a financially viable restructuring of the ISS are required. *Mitigation*: In the ISS, the restructuring effort supported by this operation will separate health insurance from health care provision. This will allow the EPS-ISS to concentrate on the processes within its purview (e.g., signing up members, compensation, contracting health care services) and establish a contractual relationship with the ESEs. These two factors will put

[18] Significantly, this commitment was also evident during program preparation. In addition to mission opening and closing meetings, senior government officials attended technical meetings as well (Deputy Minister of Finance and Public Credit, Deputy Director of the DNP, the Minister for Social Welfare, and the ISS Chairman).

pressure on the EPS-ISS to make more efficient use of its resources and ensure the quality of its services. Meanwhile, as the ESEs will have a transition period during which their services will be contracted by the ISS and will receive operational support, they will have enough time to adjust so that they can compete with other providers.

e. Incentives are needed for participating agencies (the ISS and the Ministry for Social Welfare) to fulfill the conditions set forth in the matrix. *Mitigation*: An incentive for the Ministry's fulfillment of the conditions is provided by the link between the conditionality of the process and the budgetary allocation assigned to the Ministry for Social Welfare to fund its implementation of this reform process. In the case of the EPS-ISS, an incentive is provided by the competition to be faced in the market. A similar situation exists in the case of the ESEs that operate under the Ministry for Social Welfare.

POLICY MATRIX
HEALTH CARE AND SOCIAL SECURITY REFORM PROGRAM (CO-0265)

COMPONENT	FIRST TRANCHE (US$250 MILLION)	SECOND TRANCHE (US$150 MILLION)
A – Macroeconomic stability ***Objective: Maintain a stable macroeconomic environment.***	(1) Compliance with the guidelines established in the policy letter, maintenance by the borrower of a macroeconomic environment consistent with the program's objectives.	(2) Compliance with the guidelines established in the policy letter, maintenance by the borrower of a macroeconomic environment consistent with the program's objectives.
B – Efficiency and financial sustainability of the SGSSS ***Objective: Increase the coverage, quality, and equity of health care for the poorest sectors and build a sustainable financial foundation for the health care system.***	(3) *Subsidized health care system*. Coverage of the subsidized health care system to be increased between June 2002 and June 2003 by 320,000 beneficiaries.	(4) *Subsidized health care system*. Coverage of the subsidized health care system to be increased between July 2003 and December 2004 by 800,000 beneficiaries.
	(5) *Public hospitals* ➢ Approval of legal provisions establishing a policy for the reduction of supply-side subsidies at the departmental level. ➢ No transfers are to have been made by the central government to public hospitals to finance any services for which delivery targets have not been set. ➢ A total of 18 public hospital structural reorganization agreements are to have been signed. ➢ Approval of a plan for restructuring the public hospitals, in addition to the above-mentioned agreements, with the objective being to achieve a 20% supply-side reduction in expenditure for the hospitals undergoing structural reorganization while maintaining service portfolio and quality at aggregate delivery levels consistent with demand.	(6) *Public hospitals* ➢ Approval of an action plan to identify methods of payment for use by subnational units in compensating public or private IPSs. ➢ Approval and implementation of a plan of action for redirecting supply-side subsidies to promote the expansion of health insurance coverage. ➢ No transfers are to have been made by the central government to public hospitals to finance any services for which delivery targets have not been set. ➢ Satisfactory progress toward achieving the benchmark objectives established in the 18 public hospital structural reorganization agreements. ➢ Satisfactory progress toward achieving the benchmark objectives established in the public hospital restructuring agreements, including the rationalization of supply and hospital consolidation.
	(7) *Reduction of evasion and avoidance in the SGSSS*. Design of a reporting system to aid in developing means to control evasion and avoidance.	(8) *Reduction of evasion and avoidance in the SGSSS*. Satisfactory progress in the implementation of the reporting system and toward achievement of the targets set for the control of evasion and avoidance.
	(9) The POS. Submission of a progress report on: (i) the design of a methodology for the regular review and assessment of the POS-UPC; and (ii) a timetable for its implementation.	(10) *POS*. ➢ Approval of legal provisions to permit the modification of the POS-UPC so that the value of the UPC or the content of the POS can be adjusted as necessary to contribute to the financial equilibrium and the cost effectiveness of the service. ➢ Undertake the first technical evaluation based on the POS-UPC monitoring and assessment methodology.
C – Efficiency and financial sustainability of the ISS *Objective: Contribute to the construction of a sustainable financial foundation for the ISS to an improvement in service quality.*	(11) *Restructuring the ISS.* ➢ Approval of the legal provisions required to restructure the ISS. ➢ Approval of an action plan for restructuring the EPS-ISS and the ESEs.	(12) *Restructuring the ISS.* ➢ Satisfactory progress in implementing the action plan for restructuring the EPS-ISS and the ESEs.
D – Efficiency, transparency and equity in the CCFs *Objective: Create institutional mechanisms for ensuring transparency, accountability, and equity in the CCFs.*	(13) *Transparency, oversight, and equity* ➢ Establishment of a regulatory framework for maintaining CCF transparency and accountability as provided for in Act No. 789 of 2002 and approval of a plan of action for its implementation. ➢ Regulation of the monetary subsidies provided by the various CCFs in order to level them out across regions; establishment of goals for implementation of these subsidies.	(14) *Transparency, oversight, and equity* ➢ Satisfactory progress in carrying out the plan of action for the establishment of a regulatory framework to maintain CCF transparency and accountability as provided for in Act No. 789 of 2002. ➢ Satisfactory progress toward meeting the goals set for the implementation of the new CCF monetary subsidies.

MEANS OF VERIFICATION
HEALTH CARE AND SOCIAL SECURITY REFORM PROGRAM (CO-0265)

Component	First tranche	Means of verification
A – Macroeconomic stability ***Objective: Maintain a stable macroeconomic environment.***	(1) Compliance with the guidelines established in the policy letter, maintenance by the borrower of a macroeconomic environment consistent with the program's objectives.	CONFIS report on the borrower's macroeconomic environment, to include, inter alia, the findings of the latest review of the borrower's fulfillment of the SBA negotiated with the IMF.
B – Efficiency and financial sustainability of the SGSSS ***Objective: Increase the coverage, quality, and equity of health care for the poorest sectors and build a sustainable financial foundation for the health care system.***	(3) *Subsidized health care system*. Coverage of the subsidized health care system to be increased between June 2002 and June 2003 by 320,000 beneficiaries.	Certification by the Ministry for Social Welfare of further expansion of the subsidized system's coverage.
	(5) *Public hospitals* ➢ Approval of legal provisions establishing a policy for the reduction of supply-side subsidies at the departmental level.	Legal provisions approved and published.
	➢ No transfers are to have been made by the central government to public hospitals to finance any services for which delivery targets have not been set.	Certification by the Ministry for Social Welfare that no transfers have been made to public hospitals to finance any services for which delivery targets have not been set for 2003.
	➢ A total of 18 public hospital structural reorganization agreements are to have been signed.	Agreements duly signed by authorized representatives of the Ministry for Social Welfare and 12 subnational units for the structural reorganization of 18 public hospitals. These agreements are to include baselines and goals for staffing adjustments, achievement of a financial balance, aggregate production level consistent with demand and the portfolio of network services, and service quality.
	➢ Approval of a plan for restructuring public hospitals, in addition to the above-mentioned agreements, with the objective being to achieve a 20% supply-side reduction in expenditure for the hospitals undergoing structural reorganization while maintaining the aggregate production level consistent with demand and the portfolio of network services, and service quality.	Approval by the Ministry for Social Welfare of a plan for restructuring public hospitals which will provide for the operational rationalization of an additional 132 hospitals in 2003-2007, as well as the criteria that will serve as a basis for identifying and establishing the annual targets that will be an integral part of the performance and loan agreements.
	(7) *Reduction of evasion and avoidance in the SGSSS*. Design of a reporting system to help control evasion and avoidance.	Approval by the Ministry for Social Welfare of a document on (1) the technical design of the reporting system developed for the purpose of reducing evasion and avoidance. This document is to delineate: (i) the conceptual model for this comprehensive reporting system; (ii) its structural components; and (iii) an annual work plan; and (2) the strategy and targets for the reduction of evasion and avoidance.
	(9) The POS. Submission of a progress report on: (i) the design of a methodology for the regular review and assessment of the POS-UPC; and (ii) a timetable for its implementation.	Approval by the Ministry for Social Welfare of a document stipulating: (i) what elements the review and assessment methodology should contain; (ii) what activities should be carried out; and (iii) a timetable for the development of each element.
C – Efficiency and financial sustainability of the ISS *Objective: Contribute to the construction of a sustainable financial foundation for the ISS to an improvement in service quality.*	(11) *Restructuring the ISS.* ➢ Approval of the legal provisions required to restructure the ISS.	Approval of the relevant legal provisions.
	➢ Approval of an action plan for restructuring the EPS-ISS and the ESEs.	Approval by the borrower of the EPS-ISS component of the action plan. This document is to stipulate: (i) baseline financial indicators and annual targets; (ii) baseline performance indicators and annual targets; and (iii) the cutoff date after which the borrower's financing for retiring ISS employees will increase and a timetable indicating how the financing will be done. Approval by the borrower of the ESE component of the action plan. This document is to stipulate areas of action for the institutional strengthening of the ESEs, expected outcomes, and an implementation timetable. The activities will include studies for each ESE to define its adjustment and strengthening plan.

Component	First tranche	Means of verification
D – Efficiency, transparency and equity in the CCFs *Objective: Create institutional mechanisms for ensuring transparency, accountability, and equity in the CCFs.*	(13) *Transparency, oversight, and equity* ➢ Establishment of a regulatory framework for maintaining CCF transparency and accountability as provided for in Act No. 789 of 2002 and approval of a plan of action for its implementation. ➢ Regulation of the fees charged by the various CCFs in order to level them out across regions; establishment of goals for implementation of these fees.	Approval of the relevant legal provisions. Approval by the Ministry for Social Welfare of the plan of action, together with an indication of the time periods involved in securing approval of pending legal provisions. Approval of the relevant legal provisions, which is to include the targets for implementation thereof. .

Component	First tranche	Means of verification
A – Macroeconomic stability ***Objective: Maintain a stable macroeconomic environment.***	(2) Compliance with the guidelines established in the policy letter, maintenance by the borrower of a macroeconomic environment consistent with the program's objectives.	CONFIS report on the borrower's macroeconomic environment, to include, inter alia, the findings of the latest review of fulfillment of the SBA negotiated with the IMF.
B – Efficiency and financial sustainability of the SGSSS ***Objective: Increase the coverage, quality, and equity of health care for the poorest sectors and build a sustainable financial foundation for the health care system.***	(4) *Subsidized health care system*. Coverage of the subsidized health care system to be increased between July 2003 and December 2004 by 800,000 beneficiaries.	Certification by the Ministry for Social Welfare of further expansion of the subsidized system's coverage; 600,000 of the new memberships will be financed by the SGP, while 200,000 spots will be freed up by screening the list of persons registered with the subsidized system.
	(6) *Public hospitals* ➢ Approval of an action plan that includes definition of payment methods for use by subnational units in compensating public or private IPSs.	Approval of the action plan by the Ministry for Social Welfare.
	➢ Approval and implementation of a plan of action for redirecting supply-side subsidies to promote the expansion of health insurance coverage.	Preparation of the plan of action by the Ministry for Social Welfare and approval by the CNSSS; evaluation of progress in its implementation.
	➢ No transfers are to have been made by the central government to public hospitals to finance any services for which delivery targets have not been set.	Certification by the Ministry for Social Welfare that no transfers have been made to public hospitals to finance any services for which delivery targets have not been set for 2004.
	➢ Satisfactory progress toward achieving the benchmark objectives established in the 18 public hospital structural reorganization agreements.	Approval of a report by the Ministry of Social Welfare on the staff adjustment targets, achievement of financial balance and production and service quality established in the agreements for structural reorganization of 18 public hospitals. This report will provide data on fulfillment of cumulative annual targets at 31 December of the year preceding to the date on which all the conditions for the second tranche are considered fulfilled.
	➢ Satisfactory progress toward achieving the benchmark objectives established in the agreements for the structural reorganization of the public hospitals, including the rationalization of supply and hospital consolidation.	Approval of a report by the Ministry for Social Welfare on the implementation of the public hospital structural reorganization agreements based on annual targets for hospitals intervened and annual spending reduction targets for those facilities. The measurements of financial results and maintaining service portfolio and quality at aggregate delivery levels consistent with demand will be evaluated in the aggregate for all hospitals intervened using the baseline set in the restructuring agreements (service portfolio and quality at aggregate delivery levels consistent with demand). These targets will be cumulative for all hospitals intervened and will be measured based on the project cycle at 31 December of the year preceding the date on which all the conditions for the second tranche are considered fulfilled.
	(8) *Reduction of evasion and avoidance in the SGSSS*. Satisfactory progress in the implementation of the reporting system and toward achievement of the targets set for the control of evasion and avoidance.	Approval of a report by the Ministry for Social Welfare on (1) progress in implementing the work plan for the development of the reporting system. This will signify that all actions included in the annual work plan listed in Condition No. 7 have been completed by 31 December of the year preceding the date that fulfillment of all the conditions for the second tranche is reported; and (2) progress in implementing the strategy and targets for reducing evasion and avoidance.
	(10) *POS*. ➢ Approval of legal provisions to permit the modification of the POS-UPC so that the value of the UPC or the content of the POS can be adjusted as necessary to contribute to the financial equilibrium and the cost effectiveness of the service.	Approval of a report by the CNSSS on the adjustment of the UPC-POS.

Component	First tranche	Means of verification
	➢ Undertake the first technical evaluation based on the POS-UPC monitoring and assessment methodology.	Preparation by the Ministry for Social Welfare of a report covering compliance with the timetable mentioned in connection with Condition No. 9 by 31 December of the year preceding the date on which all conditions for the second tranche are considered fulfilled and the findings of the technical evaluation are reported.
C – Efficiency and financial sustainability of the ISS *Objective: Contribute to the construction of a sustainable financial foundation for the ISS to an improvement in service quality.*	(12) *Restructuring the ISS.* ➢ Satisfactory progress in implementing the action plan for restructuring the EPS-ISS and the ESEs.	Report on the EPS-ISS component of the plan of action approved by the borrower. This document should cover progress in implementing the plan of action, with emphasis on progress in terms of the financial and performance indicators delineated in connection with Condition No. 11. The following indicators will be used: (i) percentage of members receiving compensation will be used as an indication of improvements in information management; (ii) level of collections of fees and co-payments, which will also be used as an indication of the monitoring of revenue flows; (iii) average costs per member will be used as an indication of progress in expenditure and contract management; and (iv) operational profit margins will be used as an overall indicator of financial performance, excluding the cost involving retired ISS employees. The benchmarks to be reached for each indicator are those corresponding to 31December of the year preceding the date on which all conditions for the second tranche are considered to have been fulfilled. Approval of the legal provisions and appropriation of necessary funds pursuant to which the borrower increases its financing of the pension benefits of persons retiring from the ISS, based on the cutoff date and timetable set out in the plan of action mentioned in Condition No. 11. Report on the ESE component of the plan of action approved by the borrower. This document covers progress in implementing the plan of action for the institutional strengthening of the ESEs as established in Condition No. 11. This document will include the studies and plan of action specific to each ESE, together with financial, quality, and performance indicators and evidence of their progress. Specifically in relation to institution-strengthening, the following steps will be taken in keeping with the timetable: (i) consolidation of the legal platform; (ii) introduction of management, financial, and administrative procedures; (iii) organization of service delivery; and (iv) monitoring and assessment of the process. The targets toward which progress must be shown in terms of these financial and performance indicators are those corresponding to 31 December of the year preceding the date on which all conditions for the second tranche are considered to have been fulfilled.
D – Efficiency, transparency and equity in the CCFs *Objective: Create institutional mechanisms for ensuring transparency, accountability, and equity in the CCFs.*	(14) *Transparency, oversight, and equity* ➢ Satisfactory progress in carrying out the plan of action for the establishment of a regulatory framework to maintain CCF transparency and accountability as provided for in Act No. 789 of 2002. ➢ Satisfactory progress toward meeting the goals set for the implementation of the new CCF monetary subsidies.	Report on progress in implementing the plan of action approved by the Ministry for Social Welfare. More specifically, the report should cover progress in the establishment of the regulatory framework made by 31 December of the year preceding the date on which all conditions for the second tranche are considered to have been fulfilled. Report on progress toward the goals set for the implementation of the fee structure made by 31 December of the year preceding the date on which all conditions for the second tranche are considered to have been fulfilled.

OUTPUT MATRIX
HEALTH CARE AND SOCIAL SECURITY REFORM PROGRAM (CO-0265)

Problem to be addressed	Proposed reform	Output indicators 6-12 months post-PBL	Outcome indicators: 3 years post-PBL	Information source
Insufficient health insurance coverage of population living in extreme poverty	Expansion of subsidized health care system's coverage of the poorest sectors of the population	At least 1.1 million persons living in extreme poverty (SISBEN 1 and 2) who were not covered in 2001 are covered under the expanded subsidized system in December 2004 (Note: 1.1 million is used from July 2002 to December 2004; after which the baseline is the number covered as of December 2001)	At least 0.7 million people living in extreme poverty (SISBEN 1 and 2) who were not covered in 2004 are covered under the expanded subsidized system in 2005-2007	Routine reports channeled through Synergy by the CNSSS, the DNP and the Superintendency for Health Care
Inefficiently run public hospitals that provide poor quality service, lack financial sustainability and thus have a negative fiscal impact on national and subnational accounts	Structural reorganization of public hospitals and reduction of supply-side subsidies while maintaining service delivery volumes and quality	40 public hospitals having undergone restructuring, with an average reduction in total expenditure equivalent to 20% of 2002 spending levels while maintaining service delivery volumes and quality	No annual transfers have been made to public hospitals to finance any services for which delivery targets have not been set between 2003 and the time of evaluation Savings by public hospitals as a result of the rationalization program total at least US$150 million as compared to 2002 spending levels	Report evaluating Ministry for Social Welfare-Department management contracts for participating hospitals; special report by the Ministry for Social Welfare and the Ministry of Finance and Public Credit
Cost and content of existing POS-UPC are contributing factors to financial imbalances and include non-cost-effective treatments	Rationalization of the POS-UPC	The findings of the first technical evaluation of the POS-UPC are that a financial balance exists and that treatments are cost effective	The financial equilibrium of the POS-UPC is maintained over time	Special analysis prepared by the Ministry for Social Welfare, the DNP, and the CNSSS
The ISS is experiencing an increasingly serious financial imbalance which negatively impacts its financial sustainability in the medium and long terms, as well as its service quality	Restructuring of the ISS	EPSs: Indicators consistent with the targets set in the management plans: Percentage of member compensation rises from 58% in 2003 to 70-80% by end 2004 Actual collection of fees and co-payments climbs from 32% in 2003 to 75-85% by end 2004 Average cost per member falls from 114.7% in 2003 to 100-110% of UPC by end 2004 ESEs: Indicators consistent with the targets set in the management plans: Accreditation: 70-90% of ESE clinics and CAAs are accredited by end 2004 Studies and proposals for the reorganization, redesign, and modification of each ESE are ready and being implemented by end 2004	EPSs: Indicators consistent with the targets set in the management plans: Percentage of member compensation is 85-95% by end 2007 Actual collection of fees and co-payments is 85-95% by end 2007 Average cost per member is 90-100% of UPC by end 2007 ESEs: Indicators consistent with the targets set in the management plans: Accreditation: 50% of ESE clinics and CAAs are accredited by end 2007 50% of reorganization plans have been implemented by end 2007	MPS Accreditation Registry reports Evaluation reports based on EPS/ISS customer satisfaction surveys Financial evaluation reports on entities Evaluation report on entity service delivery logs

Bogota, Friday, 19 September 2003

Mr. ENRIQUE IGLESIAS
President
INTER-AMERICAN DEVELOPMENT BANK
Washington, D.C.

Dear Mr. Iglesias:

Since the Álvaro Uribe Vélez Administration took office in August 2002, the definition of a broad-based lending program by the Inter-American Development Bank for the period 2003-2006 has been one of the most cogent shows of support for the country. The announcement of programs by multilateral development agencies, particularly the Inter-American Development Bank and the World Bank, helped to restore confidence in the Colombian economy's stability and its market access. This show of confidence has been of paramount importance in paving the way for an ambitious program of reforms, many of which have already been passed by Congress.

Within the framework of its medium- and long-term economic and social policy, the Government of Colombia is designing a social reform package and is seeking financial support from the Bank for its successful implementation, together with technical assistance and its ongoing collaboration in the design of support mechanisms for these reforms.

In addition, the government is working to secure and mobilize resources on favorable terms for the country. This effort is aimed at providing support for adjustments in sector policies, the implementation of institutional changes, and mitigate the short-run adverse impacts of the fiscal adjustment program now being carried forward.

Within this context, on 23 March 2003 the Government of Colombia signed an agreement with the Inter-American Development Bank to launch the Social Emergency Program. This program's main objectives are to backstop the government's efforts to maintain macroeconomic and fiscal stability, mitigate the potential effects of the fiscal adjustment and the armed conflict on the sectors of the population living in extreme poverty, and promote the continuation of the social reforms now under way. The Social Emergency Program is being implemented in a suitable manner, and all the appropriate policy and institutional actions are being conducted in order to qualify for the second disbursement under this operation.

This letter's purpose is to provide information on the background and context for the design and development of the Health Care and Social Security Reform Program in Colombia. The government is aware that some risk factors exist which could pose a threat to the satisfactory implementation of this new operation. These risks include an unforeseen increase in security expenditures, insufficient support for the economic initiatives included in the referendum, and heightened volatility on external markets. In

view of these risk factors, the government has identified contingency measures for safeguarding the program. These measures include additional taxes and the early introduction of some of the measures discussed herein.

The policies included in this operation are the outcome of a wide-ranging exchange of ideas between the Bank's and the government's teams, with the latter including representatives of the Ministry of Finance and Public Credit, the Departamento Nacional de Planeación [National Planning Department] (DNP), the Ministry for Social Welfare, and the Social Security Institute (ISS). As a result of this dialogue, a program has been devised that will permit the government to implement a structural reform package aimed at improving the coverage, quality, equity, and financial sustainability of the health care sector and the social security system over the medium term.

I. Macroeconomic Stability

1. In 1998-1999, Colombia was hit by the worst recession it had experienced in 70 years. In 1998 gross domestic product (GDP) grew by a scant 0.6% and in 1999 it shrank by 4.2%. The recession was marked by a deterioration in the nonfinancial public sector's accounts, with the deficit reached a record figure of 5.5% of GDP. This situation was largely attributable to the spending overages that began to occur from 1994 on, in particular, in both central government and subnational government accounts, which put public finances in an untenable situation, and to the worldwide crisis that broke out in late 1997.

2. Colombia has been recovering from the 1998-1999 crisis despite the intensification of violence in the country and the existence of an adverse international environment. The fiscal consolidation effort has moved ahead, inflation has declined, and the financial system has been restructured. By early 2002, these advances had enabled the country to gain access to international credit markets and had ensured the currency's stability.

3. However, in mid-2002 the country was overtaken by the ramifications of regional instability: sovereign bond spreads widened considerably, and the peso consequently depreciated. This state of affairs was exacerbated by the fiscal deficit and by the intensification of the armed conflict to an extent not seen in some time owing to the outcomes of the peace processes being pursued at that time.

4. The new Administration has moved swiftly to deal with the adverse regional environment and its serious fiscal problems. First, it proposed (and won passage of) major budget cuts for 2003. In fact, these reductions have been so significant that the increase in expenditures other than interest payments will be below the expected inflation rate. Second, a one-time levy on net worth was instituted, and an unprecedented package of tax and expenditure control measures was brought before Congress. And third, executive orders have been issued that will reduce spending, benefits and subsidies: the Certificado de Reembolso Tributario [Certified Tax Drawback] (CERT) rate was lowered to zero, as were extra-legal benefits at the subnational level, and vacant posts that had not

been filled since July 2002. At the same time, the government began to work on designing and implementing an ambitious program aimed at reducing and restructuring the civil service.

5. During 2002, real GDP growth verged on 1.7%; inflation amounted to 6.99%, the current account deficit held at around 1.9% of GDP, and net international reserves rose by approximately US$188 million. In 2003, economic growth is expected to recover within a context of stability: the growth rate will be between 2% and 2.5%, inflation will hover between 5% and 6%, and the current account deficit will be about 2.9% of GDP.

6. As far as the fiscal situation is concerned, at the close of 2002, the consolidated deficit totaled 3.6% of GDP, which was 1.4 points above the original target negotiated with the International Monetary Fund. This divergence is largely accounted for by a higher level of outlays (partly as a consequence of the elections) and by a slowing of economic growth in 2001 and the first half of 2002, which depressed tax collections.

7. Initially, the fiscal deficit targets for the consolidated public sector agreed upon with the IMF for 2003 and 2004 were 2.5% and 2.1% of GDP, respectively. But since a budget addition had to be requested from Congress in the second half of the year, increasing these targets to 2.8% of GDP in 2003 and 2.5% of GDP in 2004 is being considered. In order to meet its fiscal target, the government has initiated a strategy based on two main elements. First, if the referendum is passed, civil service expenditure levels will be frozen in nominal terms during 2003 and 2004. This initiative is expected to generate direct savings of 0.7% of GDP ($1.5 billion) in 2003 and 1.3% of GDP ($2.9 billion) in 2004. Second, the tax reform will boost revenues by 1% of GDP in 2003 and 2004.

8. The government's program is focused on guaranteeing fiscal sustainability and, ultimately, restoring security, achieving a recovery in economic growth, and increasing social equity. The fiscal adjustment and structural reforms will ensure the achievement of these objectives within a stable macroeconomic environment backed up by prudent monetary policies and a stronger financial system. At the same time, steps will be taken to reinforce social welfare programs, expand the coverage of education and health care services, and mitigate the impact of public utility rate hikes on the poorest sectors of the population.

9. Within this framework of macroeconomic stabilization, the Colombian government signed a stand-by arrangement (SBA) with the IMF for SDR 1.548 billion over the coming two years. One of the program's main objectives is to reduce the fiscal deficit by the equivalent of two points of GDP. This reduction is to be achieved by raising tax revenues through implementation of the new tax reform provisions and freezing current national expenditure for two years. In the medium term, structural reforms such as the pension reform initiative that was recently passed by Congress and the State modernization program will help to ensure the sustainability of the debt and consolidate the adjustment process begun by this Administration. The chief targets included in the SBA for 2003 are a nonfinancial public-sector deficit of 2.5% of GDP, a current account deficit of 0.8% of GDP, and inflation of between 5% and 6%.

10. The reinforcement of public finances is one of the key elements of the strategy for restoring confidence and economic growth. The graduality of the adjustment measures for addressing the excess spending levels that remain in the public sector will be financed with the savings generated by the private-sector adjustment. The credibility of the public-sector adjustment is based on the scope of the structural reforms that are being brought forward. The stated objective is to reduce the consolidated public sector's deficit from 3.6% of GDP in 2002 to 2.8% in 2003, to 2.5% in 2004 and so on as the consolidation process continues in the years to come. The fiscal adjustment will increase the nonfinancial public sector's primary surplus from 0.8% of GDP to 2.4%, and it is expected to lower this sector's debt to below 52% of GDP.

11. The government is cognizant of the fact that the sustainability of the public debt must be underpinned by sound structural reforms rather than optimistic economic growth scenarios or incautious assumptions about the behavior of exchange or interest rates.

12. The government is also aware that some risk factors exist which could pose a threat to the satisfactory implementation of this program. Some of these risks are an unforeseen increase in security expenditures, insufficient support for the government's economic initiatives, including those covered in the referendum, and volatility in external markets.

13. If the available financing proves to be insufficient, the government will consider the possibility of temporarily making use of the Fondo de Ahorro y Estabilización Petrolera [Petroleum Stabilization and Savings Fund] (FAEP), which currently contains resources amounting to nearly 1.4% of GDP. Preliminary information on security expenditures indicates that the wealth tax earmarked for that purpose is producing higher revenues than expected. If the additional resources, in conjunction with the above-mentioned contingency measures, are not sufficient to finance unforeseen military expenditures, then the government will consider the possibility of issuing long-term bonds on concessional terms.

II. Health

14. The National Development Plan provides that the construction of a more equitable society should be one of the cornerstones of development policy. Three fundamental challenges have been identified in this connection: (i) increase the efficiency of social expenditure so that the higher level of funding translates into better outcomes; (ii) improve the targeting of expenditure so that these resources reach those who need them the most; and (iii) consolidate a social welfare system to protect the most vulnerable sectors of the population from the effects of economic crises.

15. In order to meet these challenges, the Colombian government has embarked upon the task of consolidating a strategy for protecting the poorest and most vulnerable sectors of the population by developing social welfare and prevention mechanisms. To this end, the Sistema de Protección Social [Social Welfare System] (SPS) will be established. The SPS will take the form of a policy package

aimed at reducing the vulnerability and improving the quality of life of Colombians, especially the most defenseless among them.

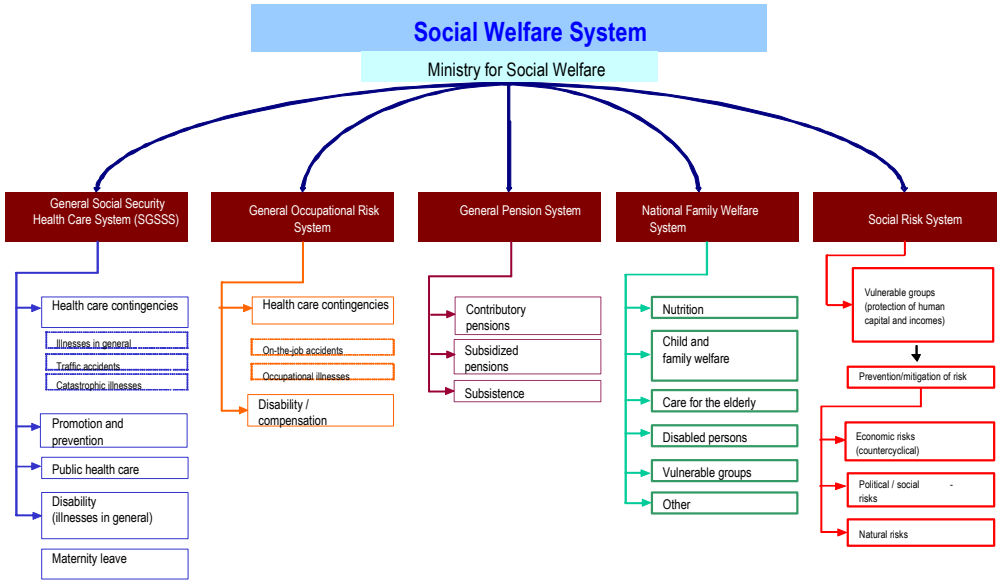
16. The first step in setting up the conceptual framework for the SPS was to create a legal and regulatory structure as a basis for making the necessary adjustments in the institutions forming part of the system. Accordingly, the legislative agenda defined by the Administration when it took office devoted special attention to regulatory issues, in particular through the labor and pension reform bill that was passed by Congress in December 2002. The new Labor Act amended employment regulations and standards, defined the nature of the SPS, and introduced provisions to support employment and the expansion of social welfare mechanisms.

17. In parallel with these efforts, work began on the development of the necessary institutional structure. The first step was to merge the ministries of labor and social security, and of health care, in order to create the Ministerio de Protección Social [Ministry for Social Welfare] (MPS), which is responsible for policymaking and coordination of the SPS. This strategy encompasses public health, social security and welfare, training, labor policy and standards, action to reduce child labor, and disability policies. The Ministry for Social Welfare is thus the decision-making body responsible for establishing policy guidelines and ensuring inter-agency coordination among the members of the SPS[1].

18. The components of the SPS and the principal benefits they provide to the population are outlined in Figure 1. The Ministry for Social Welfare oversees the policies and regulates each of the subsystems with the assistance of and in coordination with its auxiliary bodies (SENA, ICBF, Superintendencies), other public, private and cooperative organizations (public and private providers, the Cajas de Compensación Familiar [Family Allowance Funds]), Empresas Promotoras de Salud [Health Promotion Enterprises] (EPSs), Administradoras del Régimen Subsidiado [Subsidized System Administrators] (ARSs)), and subnational agencies.

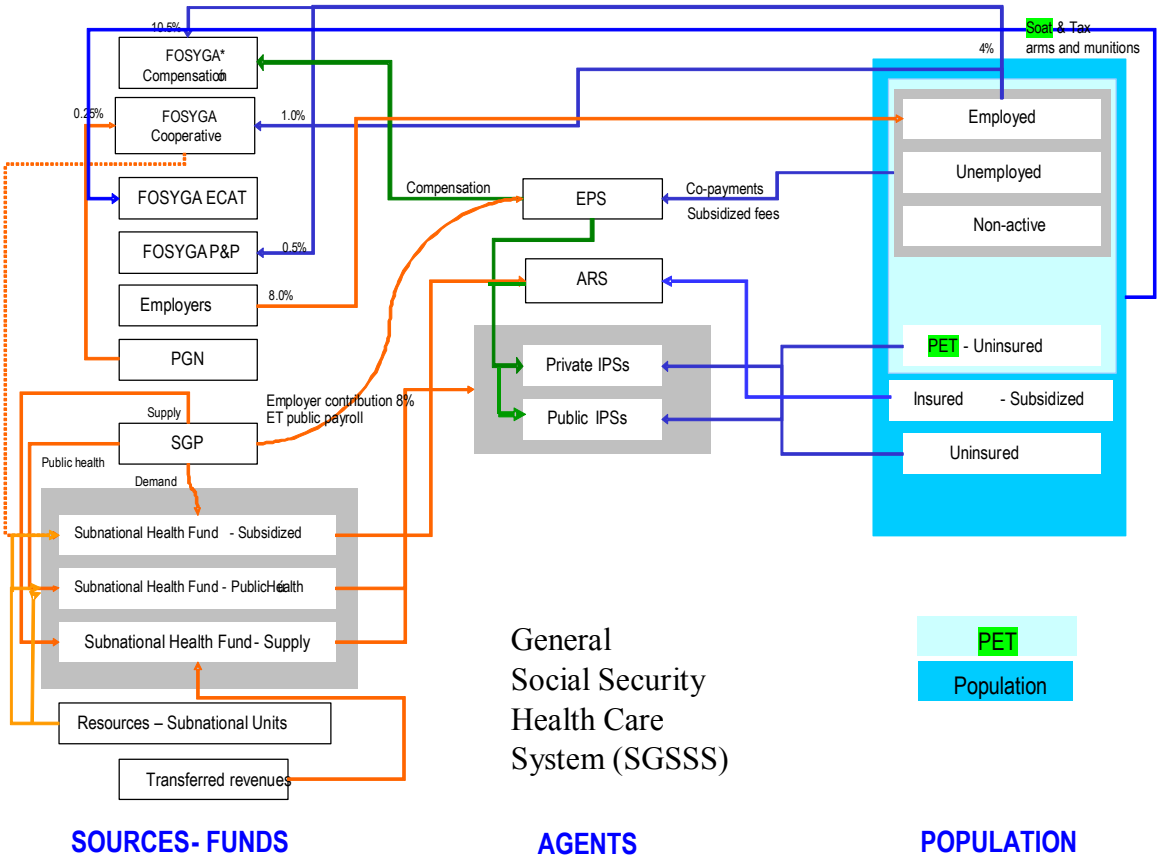
[1] The Social Welfare System consists of the following institutions: Ministry for Social Welfare, ICBF, SENA, the CCFs, pension fund managers, social welfare funds, Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund], Fondo de Solidaridad Pensional [Pension Solidarity Fund], the Family Allowance Superintendency, the National Health Superintendency, INS, INVIMA, EPSs, ARSs, IPSs, and others.

Figure 1. Social Welfare System (SPS)



19. As may be seen in figure 2, the institutional structure of each subsystem of the social security health care subsystem has been specifically designed to link funding sources with target population groups who benefit from the goods and services that each one provides. In this case, this institutional design takes the specialized functions of the various programs' executing agencies into account: registration of members and receipt of contributory payments, targeting, resource concentration and financial management, program implementation, policy-making and oversight, etc. In the short run, the challenge will be to find a way to galvanize the funding structure and devise effective mechanisms for channeling and integrating benefits for target groups that are consistent with the projected conditions in each. The Sistema de Clasificación de Beneficiarios de Programas Sociales [Social Program Beneficiary Classification System] (SISBEN) will play a key role in targeting these programs, as well as the design of monitoring and assessment tools.

Figure 2. Institutional Design of the SGSSS



20. Expanding the coverage of social security in health care and providing differentiated means of serving the needs of the most vulnerable groups in the population are some of the main objectives of the initiatives being pursued in the health care sector. Specifically, in public health, efforts are underway to expand vaccination coverage, reduce the incidence of malaria and dengue fever, bring down infant and maternal mortality, prevent teenage pregnancy, and treat sexually transmitted diseases.

21. Steps will be taken to help ensure the financial sustainability of the Sistema de Seguridad Social en Salud [Social Security Health Care System] (SGSSS) with a view to increasing the coverage and quality of the various levels and categories of health care services. Expanded subsidy coverage will be achieved through the Sistema General de Participaciones [General Revenue Sharing System] (SGP) and gradual shift from supply-side subsidies to demand subsidies, thus building the capacity of public hospitals to fund their expenditures by selling services. Better collections will also reduce evasion and avoidance of contributions. In addition, for the social security pension system, efforts will be made to apply a pension policy that will avert financial imbalances, improve coverage, and provide systems for covering pension liabilities in a manner that will ensure intra- and inter-generational equity.

22. The restructuring and revamping of the country's public hospitals in order to make them self-sustaining and improve their performance in the market are based on the fact that the hospitals' operations not only have a strong influence on public finances at the subnational level today, but will also, if they continue as they are now, will become financially unsustainable and generate huge liabilities, and hence costs, for the country. The reasons why insurance coverage is not greater is primarily because the hospitals' expenditures have grown beyond the levels they can cover from the sale of their services and the sector's increased funding. In addition to have a negative impact on these institutions themselves, this increase in expenditure has delayed the conversion of subsidies and the expansion of the subsidized system's coverage and has become the main cause of the nonfinancial public sector's deficits at the subnational level.[2]

23. In the medium term, these efforts to overhaul the public hospitals' pattern of expenditure and modernize their organizational and management structure will thus be reflected in a substantial reduction in their operating and cumulative deficits. The magnitude of the improvement, however, will depend on how aggressive the modernization policy is in terms of the scale of the structural reorganization and the amount of time taken up by this process; it is possible that, by the end of the four years, an investment on the order of US$250 million could result in savings equivalent to up to 0.5% of GDP. However, fiscal constraints have kept investment small at an estimated US$108 million for 2003 to 2007.

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[2] According to the Banco de la República, *"the deficit built up by the nonfinancial public sector at the subnational level in 2001 is largely attributable to the performance of decentralized agencies, which posted the highest expenditure levels. This was especially true of departmental agencies. Taken together, this level of government ran a deficit totaling $656.5 billion. The public hospital had the largest deficit ($596 billion)"*, Banco de la República, Subgerencia de Estudios Económicos, Dirección de Finanzas Públicas, Medellín, June 2002.

24. In conjunction with this adjustment and modernization strategy, the system should alter the incentives that currently contribute to the growth of the hospitals' expenditure levels. In addition to the provision of transfer payments to meet the demand for additional resources, it is also necessary for the public hospitals to work on justifying their revenues by implementing modes of payment apart from direct transfers. The payments made by the appropriate subnational units to compensate public or private IPSs for providing health care services to poor persons who are not registered with the system or do not have access to demand subsidies should be based on the purchase of health care services using modes of payment consistent with the volume and value of the services actually rendered on terms and conditions specified in the relevant contracts. Funds may be transferred only for the purpose of ensuring the provision of basic services (to be specified by the Consejo Nacional de Seguridad Social en Salud [National Council on Social Security in Health Care] (CNSSS)) by public-sector agencies in monopoly markets when efficiently-run service providers are not deemed to be financially sustainable in accordance with the terms and requirements set forth in the relevant regulation. Public hospitals' market operations shall be such as to finance their expenditures with the income generated by the sale of their services to Empresas Promotoras de Salud [Health Promotion Enterprises], administrative boards for the subsidized system, agencies for which payment for such services is mandatory, subnational units, and others that pay into the system.

25. The country's fiscal position represents a major constraint in terms of efforts to make more rapid, consistent progress in expanding health insurance coverage. In the allocation of the cofinancing available in the subaccount of the Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund] within the subsidized system, priority should be placed on ensuring the continuation of the existing membership and, budgeted resources permitting, on the expansion of the membership.

26. Efforts to finance health insurance should be accompanied by improvements in service quality and access. Quality-based management is a key element in the system's strategy. The issuance of the new regulations on service quality will allow the system to move forward with the development and ongoing improvement of quality health care systems to be administered by insurers and providers as a means of protecting the interests of the poorest sectors of the population.

27. The Ministry for Social Welfare is also developing methodological tools for carrying out annual adjustments in the benefits covered by the Plan Obligatorio de Salud [Mandatory Health Plan] (POS) and in the computation of the Unidad de Pago por Capitación [Capitation Payment Unit] (UPC). The UPC is the POS annual value per member for contribution-based and subsidized systems. The benefits plan generally includes identifying and ranking the population's health problems by priority, determining the range of available treatments for those problems, and finally deciding which of these treatments should be included in the plan, with the main criteria for this purpose being their effectiveness and cost. The generosity of the benefits plan is determined by the financial resources available for achieving coverage targets, which means that, prior to the above process, the tasks entailed in setting the plan's coverage ceilings must be completed.

28. The evaluation of these benefit plans is intended to ensure that their contents continue to fit the population's health care needs at reasonable levels of quality and cost. Conducting these adjustment (incorporation or removal of benefits) processes therefore requires information on changes in

epidemiological and in service-use profiles of the population, in medical technology, and in funding. Adjustments in the content of benefit plans also, of course, entails and adjustment in their price.

29. The benefit plan's price must also be adjusted periodically in order to take account of factors generating foreseeable changes in provider costs (e.g., health status of members, costs of local inputs, local operating conditions, other special circumstances) or changes in costs over time (e.g., inflation, changes in technology, praxis, or market conditions).

30. Given the above, the evaluation and possible adjustment of the benefit plans and the UPC requires the necessary information for conducting economic assessments of POS contents and econometric analyses of the insured population's service demands. Development and implementation of the Sistema Integral de Información en Salud [Integrated Health Care Information System] (SIIS) will be essential to this and to reducing evasion and avoidance of social security contributions, as will an overarching strategy that encompasses: (a) membership databases; (b) collection systems; and (c) member registration procedures. The purpose of this consolidation is to facilitate cross-checking, cut down on multiple memberships, and streamline fee payment and membership registration procedures.

31. In summary, this strategy will enable Colombia to make important strides toward resolving the main problems it faces in the health care sector. The government is committed to making these policy changes and ensuring the continuity of the structure, rationalization, and strengthening of the SPS.

III. Social Security: Instituto de Seguros Sociales [Social Security Institute] (ISS)

32. The ISS was created by Act No. 90 of 1946 as an industrial and commercial State enterprise reporting to the Ministry of Labor and Social Security under the provisions of Executive Order No. 2148 of 1992 and Act No. 100 of 1993. It is authorized to administer the health insurance, pensions, and occupational risk insurance provided under the Sistema de Seguridad Social Integral [Integral Social Security System].

33. Before Act No. 100 of 1993 entered into force, the ISS was both a health care insurer and provider, and no distinction was made between the two functions. These activities were financed with affiliated worker and employer contributions, which amounted to 8% of employees' wages.[3] Thus, the ISS was the main provider of both health insurance and health care provision, which

[3] Two-thirds of these contributions were paid by the employer. This proportion was maintained after the reform process.

were mandatory under the terms of the corresponding labor contracts, for the economically active population in the country. The ISS was able to maintain this position fairly easily because it had no real competition in the market.[4] The ISS' monopoly position and its presence in almost all parts of the country also gave it very little incentive to focus on administrative modernization.

34. Act No. 100 of 1993 created a new set of conditions under which the ISS lost its dominant position in the health insurance market as private organizations were allowed to compete with it. In this new framework, health care contributions are set at 12% of each member's wage, but total collections are no longer paid into the ISS. These revenues are translated into a set amount per person (adjusted for each member's age, gender, and geographical location), the UPC. The level of the UPC is set by the CNSSS. Revenues are drawn from an account set up under a crossed-account arrangement between the EPSs and the Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund], and all of the contributions are paid into that account.[5] At the same time that contributions were increased, benefits under the contributory system were extended to members' nuclear families (beneficiaries).

35. According to a study conducted by the Consejo Nacional de Política Económica y Social [National Council on Economic and Social Policy (CONPES)], the health care business sector has accumulated a current deficit since 1998, owing to high fixed costs in the areas of personal services, retirement plan payments to ISS pensioners, and overhead. Based on this analysis, the CONPES has concluded that the ISS is not financially viable under its existing organizational structure. It does not have suitable member information systems, suffers from a lack of management capacity for IPS oversight, does not have ongoing strategies for information screening and updating, has cost overages attributable to a failure to monitor the provision of health care, employs practices for earmarking physical and financial resources that could be streamlined with the help of a good information system, has high operating and labor costs, and fails to place priority on promotion and prevention. In short, the institution suffers from an exceedingly wide range of problems caused by inefficiency and by a lack of administrative and financial capacity which place it in a weak and precarious position vis-à-vis its competitors.

36. The factors contributing to the ISS's poor performance can be summarized as follows: (i) an inability to adapt to the competitive environment established under Act No. 100 of 1993; (ii) unsatisfactory information systems; (iii) inflexibility in labor costs and expenditures (collective bargaining agreement); (iv) low productivity; and (v) inefficient management.

37. In order to resolve this situation, CONPES document 3219 called for a structural reform that will allow the institution to reduce its operational and labor cost rigidities, overhaul its

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4 Pension and insurance funds became the natural competition for the ISS.

5 The use of the UPC for each actual member, based on member characteristics, is called "compensation". It total contributions exceed the total sum represented by the UPCs, then the EPSs transfer the surplus to the Solidarity and Guarantee Fund, and vice versa.

management systems, enhance its income-generation capacity, and achieve functional separation of business areas, a better information and record-keeping system, and proper technical and operational planning.

38. Negotiations and consultation between the institution and the trade union failed to produce any agreed formula for defining and implementing the necessary institutional adjustments, however. The Colombian government therefore proceeded to issue Executive Order No. 1750 of 2003, which split off the service provision component from the ISS and created seven Empresas Sociales del Estado [State social enterprises] (ESEs), under the Ministry for Social Welfare. These enterprises are legal entities in their own right, enjoy administrative autonomy, and have their own assets. This order also defines the nature of the ISS as an insurer for pensions, health care (EPS), and occupational risks while eliminating most of its labor costs and benefit liabilities. The new service providers are also endowed with a legal structure for the employment of public-sector workers not covered by a collective labor agreement. These changes make the two businesses independent from one another. A three-year transition period is provided for however. During this period the ISS, acting as an EPS, will engage the ESEs to provide health care for its members, with the amount and quantity of such services being subject to the portfolio that each ESE is able to offer.

39. Within each ESE, health care networks will be set up in which the demand for medical services will be channeled through out-patient facilities known as Centros de Atención Ambulatoria (CAAs). This system will reduce congestion the Level II and III clinics, will permit more information to be gathered on the members and their demographics, and will pave the way for the development of promotion and prevention programs for the members of each CAA.

40. Long-term restructuring measures involve changing the nature of most employer-employee relationships, such that they are not covered by the current collective bargaining agreement. This change will help stem the growth of pension liabilities and the labor rigidities described above. From the time the benefits are unbundled, the EPS will absorb payments to all current retirees under the preferential system, and a large portion of union workers covered by a collective bargaining agreement. The national government, for its part, will step up funding for payments to retirees previously employed by the ISS, contributing to medium- and long-term financial stability.

IV. Cajas de Compensación Familiar [Family Allowance Funds] (CCFs)

41. The passage of Act No. 789 of 2002 provides for the performance of more social services by the CCFs with a view to giving them with the full economic and cultural content which the Constitution intended to endow to the welfare State under the rule of law. The main objective of these changes is to ensure that mechanisms exist for the distribution of social benefits to workers and the

unemployed by giving the CCFs a larger societal role. This will permit greater democratic coverage for worker participation in the achievement of these social goals.

42. Major changes will be made in the family allowance system to be administered by the CCFs system in order to give it a greater redistributive role and wider coverage. The proposal calls for: (i) changing existing conditions for worker access and allowing unemployed heads of household to join; (ii) lowering the wage limit for eligibility for the monetary subsidy from four to three times the minimum wage; (iii) entitling unemployed beneficiaries to draw a subsidy that includes health plan contributions for a specified period to be determined on the basis of the availability of budgeted funds; (iv) entitling unemployed persons who had previously joined a CCF to benefit from recreation and tourism services based on the length of membership; (v) providing relevant vocational training to unemployed persons who had been in the system for more than a year immediately before becoming unemployed in order to enhance their chances of finding employment; and (vi) having the CCFs provide credit for microenterprises.

43. The new legal provisions assign a highly significant economic and social role to the CCFs. On the economic front, they will be able to invest in the financial sector through banks, financial cooperatives, and commercial finance companies, as well as in the housing market. They may also enter into partnerships and establish separate corporations to perform any activity oriented toward fulfilling their social function, and member workers may join these new entities. On the social front, they are given extraordinary responsibilities inasmuch as they are permitted to invest in any of the component regimes of the social security system, in preschools for low-income children, and in low-income housing.

44. In order to achieve greater equity in the services offered by the CCFs, efforts will be devoted to implementing provisions that will allow a greater balance to be struck between monetary and service subsidies. In other words, the aim is for all the CCFs to offer various services rather than monetary subsidies only.

45. Article 5 of Act No. 789 establishes the principle of equity and, on the basis, a mechanism for regional or departmental redistribution and compensation involving the introduction of a provision prohibiting any CCF located in a region having a lower level of social and economic development from being obligated to pay out funds for any reason to CCFs operating in regions having higher social and economic development indices. Payments made between CCFs should be based on the availability of resources, and the Superintendency will therefore make sure that payments made by each of the CCFs do not threaten their financial stability. This prohibition is thus designed to avoid situations in which CCFs in less developed regions would transfer funds to CCFs in more highly developed regions and thereby jeopardize their financial position

46. In sum, in order to ensure greater equity, the aim is to level out monetary subsidies within each department and then to transfer resources to departments having lower monetary subsidies and establish a balance between these subsidies and the other services provided by the CCFs.

47. Measures for achieving greater transparency within the system will be developed. The CCFs will refrain from engaging in adverse selection in signing up new members or providing benefits; from unduly delaying the issuance of releases and settlements to firms that have decided to discontinue their membership; and from applying unequal terms to employers wishing to terminate their membership or exerting any undue pressure in an effort to persuade employers to join the CCF or to not withdraw their membership.

48. Fuller information on members will be made available through the development of a database containing records on workers that have been beneficiaries of any of the programs. An information system will also be developed to keep track of the recipients of benefits under the unemployment program for members and under the program to be set up for non-CCF members.

49. The CCFs are to prepare a governance code. This code should be made known to all the employees of each CCF. The code will enter into force upon its approval by the board of directors and at that point effort should begin to disseminate and inculcate its contents among the members of the organization and other interested groups.

50. The government is committed to the program set forth herein and welcomes the collaboration and financial support of the Inter-American Development Bank. The government appreciates the Board of Executive Directors' readiness to consider approving a US$400 million loan for implementation of the Health Care and Social Security Reform Program for the period 2003-2005.

Cordially,

/original signed/
ALBERTO CARRASQUILLA BARRERA
Minister of Finance and Public Credit

/original signed/
SANTIAGO MONTENEGRO TRUJILLO
Director General
National Planning Department